INTIMATE PARTNER VIOLENCE: PREVALENCE AND RELATIONAL DYNAMICS

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Intimate partner violence: Prevalence and relational dynamics

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Voor jou... papa

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CONTENTS

CHAPTER 1

GENERAL INTRODUCTION

The high rates to which people worldwide experience violence by an intimate partner underscore the need to explore this dark side of intimate relationships. In order to gain an in depth understanding of this social concern, a myriad of studies have examined the risk markers, the prevalence and the health correlates of intimate partner violence (IPV). In this doctoral dissertation, we specifically focus on the prevalence and the health correlates of intimate violence. Next to the examination of the prevalence of IPV in heterosexual women and men, we examine to what extent Turkish ethnic minorities in Flanders and non-heterosexuals report IPV victimization. Both of these minority populations have been indicated to be populations at greater or at least at equal risk for IPV victimization. Additionally, we concentrate on how experience with intimate violence impacts on victims' well-being at the relationship level, more specifically victims' relational and sexual well-being with the current intimate partner. In this introductory chapter, we first specify how IPV is defined and can be theoretically understood. Next, we outline up-to-date empirical research on IPV prevalence estimates and its shortcomings. Afterwards, we discuss the theoretical framework to examine the links between IPV and relational dynamics. Finally, we conclude the introductory chapter with the research objectives of this doctoral dissertation and provide an overview of the different empirical studies.

INTIMATE PARTNER VIOLENCE

Definition

In this doctoral dissertation, we adopt the definition on intimate partner violence (IPV) from the World Health Organization. In specific, IPV is defined as "behaviour within an intimate relationship that causes physical, sexual, or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours" (WHO, 2010, p. 11). This definition covers violence by a current or a former intimate partner. Further, intimate partners may be (formerly) married or cohabiting but this is not required. Additionally, this intimate relationship does not have to involve sexual activities. This form of violence may be directed from men against women, from women against men and can occur in the context of same-sex relationships. Last, IPV is a global phenomenon without cultural or racial boundaries (Saltzman, Fanslow, McMahon, & Shelley, 1999).

Drawing from the aforementioned public health WHO definition, IPV is considered within a framework of three different categories including physical, sexual and psychological violence. Accordingly, it encompasses a wide variety of behaviours (Winstok, 2007). In this regard, it is important to note that no conceptualization of intimate violence will be able to account for every single case of partner violence (Woodin, Sotskova, & O'Leary, 2013). Although researchers are moving towards consensus when discussing the definition of IPV, it is not yet clearly agreed-upon how physical, sexual and psychological violence should be defined (Winstok, 2007; Woodin et al., 2013). This mainly counts for psychological violence within an intimate relationship (Follingstad, 2007; Winstok, 2007). Also, it has been shown that these different forms of

IPV (a) frequently co-occur in the same intimate relationship, (b) largely vary in presentation (e.g., psychological violence vs. sexual violence), and (c) might be related to different health correlates[1] (Fournier, Brassard, & Shaver, 2011; Woodin et al., 2013). In other words, IPV is a highly complex and multi-faceted phenomenon. As a result, researchers have been advised to distinguish between physical, sexual, and psychological violence in their study on IPV rather than to refer to IPV as a general construct (Fournier et al., 2011).

Because of the difficulties with defining IPV, the Centers for Disease Control and Prevention (CDC; Saltzman, Fanslow, McMahon, & Shelley, 2002) have provided an IPV surveillance with a list of acts and behaviours that are illustrative of physical, sexual and psychological violence. *Physical violence* includes – but is not limited to – scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, slapping, punching, hitting, or using a weapon (e.g., a gun, knife, or other object; Saltzman et al., 2002). *Sexual violence* comprises the use of physical force to oblige a partner to engage in a sexual activity against his/her will, whether or not this sexual act is completed (Saltzman et al., 2002). *Psychological violence* can include, but is not limited to humiliating the partner, controlling what the partner can do and cannot do, withholding information from the partner, getting annoyed when the partner disagrees, deliberately doing or saying things that makes the partner feel embarrassed or diminished, using money of the partner, taking advantage of the partner, disregarding what the partner wants, isolating the partner from family and/or friends, prohibiting access to transportation or telephone, getting the partner to engage in illegal activities, using the partner's children to control the partner's behaviour, threatening loss of custody of the children, smashing objects or destroying property, denying the partner access to money or other basic

[1]As most research on the health outcomes of IPV is based on a cross-sectional design and because research has demonstrated that some factors may simultaneously function as risk markers and health outcomes of IPV, we prefer to use the term 'correlates' instead of 'outcomes'.

resources, or disclosing information that would tarnish the partner's reputation (Saltzman et al., 2002).

The focus of the present dissertation is to investigate physical, sexual, and/or psychological IPV victimization within specific samples, including an ethnic minority population and a sexual minority population. For reasons outlined below, ethnic minorities and non-heterosexuals have been considered to be at greater or at least at equal risk for IPV victimization. Before turning to the main objectives of this dissertation, we outline the different types of IPV. How violence by an intimate partner can be theoretically understood is a pivotal topic in research and reflects one of the leading historical debates in the IPV literature (Woodin et al., 2013).

Typology of Intimate Partner Violence

Violence within intimate relationships cannot be correctly understood without recognizing that there are important distinctions in types of intimate violence and in motives for IPV perpetration (Johnson & Ferraro, 2000). In general, two different and opposing perspectives have debated the etiology of violence within intimate relationships. From a feminist perspective (e.g., Dobash & Dobash, 1979), IPV is caused by a strong, constant need of patriarchal power and control over one's partner. From a family psychology perspective (e.g., Strauss & Gelles, 1990), violence has little to do with control but is situationally provoked and results from stressors and escalated conflicts within intimate romantic relationships (Anderson, 2002, 2005; Johnson, 2008). Drawing from an extensive review of the IPV literature, Johnson (1995) and Johnson and Ferraro (2000) conclude that IPV cannot be defined as a single unitary phenomenon. Instead, they propose a typology of IPV stating that feminist theorists and family psychology theorists study two different, nonoverlapping populations that engage in distinct forms of intimate violence. These forms are named "intimate terrorism" and "common couple violence".

Intimate terrorism. When thinking about violence within a romantic relationship, most people think about intimate terrorism. More specifically, this type of violence is broadly known as the perpetration of severe physical and psychological violence by a heterosexual man against his female partner (Johnson & Ferraro, 2000). Indeed, in heterosexual relationships this type of violence is almost entirely perpetrated by men against women. Yet, it also occurs in same-sex relationships (Potoczniak, Mourot, Crosbie-Burnett, & Potoczniak, 2003; Renzetti, 1992). Intimate terrorism is embedded in a general pattern of coercive control and becomes a key feature of the intimate relationship. It refers to the systematic use of physical and psychological violence as a means of dominating, intimidating, and subjugating the partner, and is likely to escalate over time (Archer, 2000; Bradbury & Karney, 2010; Johnson, 2008; Johnson & Ferraro, 2000). A number of (clinical) studies have focused on the risk markers for intimate terrorism perpetration and found that this most severe type of IPV is often associated with clinical (e.g., personality disorders; Holtzworth-Munroe, 2000) and forensic perpetrator characteristics (i.e., a criminal history). This violence is most often detected in shelter populations, in emergency rooms, in clinical populations, and in crime surveys (Dobash & Dobash, 1979; Johnson, 2008).

Common couple violence. In the second and the most frequent type of IPV, common couple violence, one or both of the partners engage in mild to severe physical and/or psychological violence. However, neither of them uses aggression to gain long-term and general control over the other partner. Instead, the control is short-term and context specific, and is therefore also sometimes called situational couple violence. This type of violence arises from disagreements and tensed conflict situations within the relationship. Although the presence of disagreement and conflict have been shown to be natural and inevitable between partners (Bradbury & Karney, 2010), these situations may in some intimate relationships escalate to violence. As common couple violence has a completely different dynamic than intimate terrorism, it is argued that this type of

violence is likely to be uncovered in community surveys rather than in clinical or crime surveys (Johnson 2008; Johnson & Ferraro, 2000; Strauss, 2009).

In summary, a contrasting view on violence within intimate relationships was evident in the history of the IPV literature. In line with Woodin and colleagues (2013) who recently provided an overview of the historical context of IPV assessment, we believe that to capture this societal problem in its whole, documentation on IPV has to come from many different sources rather than from a single approach. This doctoral dissertation aimed to enlarge the empirical knowledge on common couple violence. We specifically adopt this family psychology perspective because, across the different chapters, we gathered our data from different population-based (representative) community surveys. Consequently, this implies that (a) we were probably not examining the most severe forms of violence within romantic relationships, which are more likely to be registered through clinical samples/crime surveys and (b) we only shed light on a part of the problem. As we will discuss in detail later in this introduction, one of the main objectives of this dissertation was to examine how lifetime IPV victimization is related to victims' current well-being within an intimate relationship. In this regard, it is of great interest to specifically explore how experiences with mismanaged conflict situations influence victims' later well-being within an intimate relationship. First, we focus on IPV prevalence (i.e., whether or not a person has experienced IPV in a defined period of time; Krahé, Bieneck, & Möller, 2005). It becomes clear from prevalence estimates described below that violence by an intimate partner is widespread and common.

PREVALENCE

We start with an overview of some noteworthy prevalence studies on IPV among heterosexual women and men. Next, we discuss the prevalence of IPV among both

ethnic and sexual minority populations. Finally, we focus on the risk markers for IPV victimization. We end this section with an overview of the caveats in the prevalence research to date.

Prevalence of Intimate Partner Violence

IPV prevalence estimates have been provided by some paramount large-scale studies within the research field worldwide. Unfortunately, almost none of these surveys incorporated questions that could determine the context in which the violence has taken in place. In other words, it is not clear whether intimate terrorism (e.g., the presence of a wide variety of control tactics) or common couple violence (e.g., the presence of conflict situations) was assessed. This is because it is only recently that researchers have started to make a difference between types of violence (Johnson, 2008). In prospect of further empirical advancements, the sampling technique is a useful and reliable clue to be used in the interpretation of the type of violence (Johnson, 2008). Hence, these population-based studies presumably estimated a lot of common couple violence.

Prevalence estimates. International research collecting information about the prevalence of violence by an intimate partner has revealed that many people in heterosexual relationships occur the risk of experiencing IPV at some point in their lives. For instance, data from the WHO multi-country study on women's health and domestic violence (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006) in 10 low and middle income countries revealed lifetime prevalence estimates for physical and/or sexual IPV ranging from 15% up to 71%, and annual prevalence rates for physical and/or sexual IPV ranging from 4% up to 54%. The world health report on violence and health (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002) showed that the lifetime prevalence for physical IPV victimization among women varies between 13% and 61%, and for sexual violence

between 6% and 59%. Population-based surveys in more industrialized countries also show that a significant proportion of people report experiencing physical violence by an intimate partner (e.g., Breiding, Black, & Ryan, 2008). For example, Breiding and colleagues (2008) examined the prevalence of IPV among 70 000 American respondents in different states and found that one in four women and one in seven men reported some form of lifetime IPV victimization. Annual prevalence estimates for physical and/or sexual IPV were 1.4% for women and 0.7% for men. To date, most population-based studies or reviews that report on IPV victimization have been conducted in the U.S. (Krahé, et al. 2005; Krug et al., 2002; Langhinrichsen-Rohling, 2010; Woodin et al., 2013). In an attempt to understand IPV and gender differences in IPV victimization from an international perspective, Krahé and colleagues (2005) reviewed data on physical and sexual violence in heterosexual relationships from 35 studies in 21 different countries outside the U.S. Lifetime prevalence estimates for physical IPV among women ranged from 2.7% to 52%. Estimates for sexual IPV varied from 7% to 76.9%. Only a small number of these 35 studies provided prevalence estimates for men and the numbers for physical IPV among men ranged from 4.1% to 19% (see Krahé et al., 2005 for a detailed overview of all studies). In general, it has been stated that the lifetime prevalence of IPV in European research lies between 10% and 32% (Muller & Schröttle, 2004). Two main conclusions can be drawn from these observations. First, prevalence numbers greatly vary across studies and second, there are substantial gender differences in IPV victimization rates. Below, we outline both aspects in more detail.

Variations in prevalence estimates. A major theme in research on IPV concerns the question "How many people experience violence by an intimate partner?". That no precise prevalence number is presented above, nor that these numbers are relatively equal among the different surveys can be explained from multiple perspectives. First, given the fact that different types of IPV exist, prevalence numbers depend on what type of violence one is talking about (Johnson, 2008). For instance, Johnson (2008) reports

that two to six million women in the U.S. yearly experience IPV by their male partner. Whereas the six million is a plausible estimate for common couple violence, the two million rather refers to intimate terrorism (Johnson, 2008). As we assume that the studies described above mainly refer to common couple violence, this variation in prevalence estimates might be explained from a second, more methodological perspective. In specific, it has been shown that prevalence estimates are impacted by the method of the survey presentation (e.g., telephone, computer, face-to-face), the time frame that is used within the survey (e.g., lifetime vs. year prevalence), the exact conceptualization of IPV used by researchers (e.g., physical, sexual, and/or psychological IPV), and whether acts of IPV are measured dichotomously or continuously (Doumas, Pearson, Elgin, & Mc.Kinley, 2008; Langhinrichsen-Rohling, 2010; Woodin et al., 2013). To summarize, prevalence estimates vary according to the assessed type of violence as well as to the used methodology. Consequently, they have to be interpreted with cautiousness. Rather than trying to grasp the most correct prevalence number, these estimates have to be understood within the unique context of that study (Woodin et al., 2013).

Gender differences. The great majority of prevalence studies focused on IPV against women. However, a variety of empirical studies relied on population-based samples and community samples that included both heterosexual women and men. These types of studies demonstrated comparable IPV victimization and perpetration rates among women and men (e.g., Archer, 2000; Strauss, 2009). For instance, based on a meta-analysis of 82 studies Archer (2000) concluded that women perpetrated slightly more physical violence against their partner than men. This gendered pattern of women being more aggressive towards their intimate partner than men has provoked substantial debate among feminist and family psychology IPV researchers for a long time (Anderson, 2002; Winstok, 2007; Woodin et al., 2013). Johnson (1995) accentuated that these gender-related debates in the research field are mainly a function of a lack of

clarity about which type of violence is being assessed in which empirical study (Langhinrichsen-Rohling, 2010). As noted earlier, different findings can be obtained from surveys conducted with clinical samples or from those focusing on community samples. In this regard, there is nowadays a growing consensus that clinical or forensic samples reveal gender asymmetrical forms of violence (i.e., male perpetration and female victimization; intimate terrorism) while community samples rather portray gender symmetry in IPV victimization and perpetration (i.e., common couple violence). The latter specifically counts for community samples gathered from countries where there are high levels of gender equality. Although it is not yet clear to date to what extent this distinction between intimate terrorism and common couple violence has importance in countries where women's status remains low (Archer, 2006; Field & Caetano, 2004), there is ample evidence that culture plays an important role in understanding the phenomenon of IPV (Langhinrichsen-Rohling, 2010). These issues on gender (a)symmetry in IPV victimization rates pertained to most of the empirical studies in this dissertation. Later in this introduction we will outline gender differences regarding IPV health correlates, which is an essential aspect in any discussion on gender (a)symmetry in the IPV literature. First, we discuss the prevalence of IPV among two specific minority populations at risk.

Prevalence of Intimate Partner Violence Among Minority Populations

As described in the WHO definition, IPV has no cultural or racial boundaries and may occur in all intimate relationships, including same-sex relationships (Saltzman et al., 1999). However, most of the initial work focused on violence within White heterosexual partner relationships (Taft, Bryant-Davis, Woodward, Tillman, & Torres, 2009). In the past two decades, an increased interest emerged in understanding how IPV manifests in minority populations in general, and in ethnic minority populations (Archer, 2006; Yick, 2007) and sexual minority populations (Balsam & Szymanski, 2005; Burke, Jordan, &

Owen, 2002) in specific. However, to date, there is still a lack of systematic research in these areas. A clear theoretical framework on IPV among both ethnic and sexual minorities is detailed within the different chapters of this dissertation but in the following paragraphs we already briefly discuss the literature on intimate violence among these specific groups.

Ethnic minorities. In the last few decades, there has been an increasing trend in migration movements, and naturalization processes have become more common in many countries (Tartakovsky & Mezhibovsky, 2012). With changing populations, reflecting larger numbers of ethnic minorities within Western nations, it becomes increasingly important to include ethnic minorities in population-based research on intimate violence. In general, ethnicity is viewed as a risk marker for female IPV victimization (Raj & Silverman, 2002): Studies comparing IPV prevalence estimates among ethnic minority women to women of the majority population usually found increased prevalence rates in the minority group (e.g., Field & Caetano, 2004; Rizo & Macy, 2011; Taft et al., 2009). For instance, recent post-hoc analyses from different large-scale studies on IPV in the U.S. (for an overview see Field & Caetano, 2004) provide higher IPV prevalence rates among Black and Hispanic women compared to White women. Two leading theories have been developed in an attempt to explain violence within ethnic minority intimate relationships (Field & Caetano, 2004; Sokoloff & Dupont, 2005). A first theory is the subculture of violence theory. In this theory, it is postulated that violence within intimate relationships is to a certain extent legitimized in some collectivistic cultures. More specifically, some cultures do not provide equal power and control to women and men, which facilitates the use of male violence against women. These cultures are often labeled as patriarchal cultures (Raj & Silverman, 2002; Tartakovsky & Mezhibovsky, 2012). A second influential theory is the structural inequality theory. This theory states that structural factors in a given society (e.g., low education, unemployment, low income, discrimination) places ethnic minorities at

increased risk for IPV victimization. Although culture is essential to understand IPV, according to this theory we cannot rest on simplistic notions of culture (Sokoloff & Dupont, 2005). Rather, there must be focused on how ethnic minorities' experiences with IPV are mediated through elevated levels of stress in response to their low socio-economic status (Raj & Silverman, 2002; Sokoloff & Dupont, 2005; Tartakovsky & Mezhibovsky, 2012). Indeed, empirical evidence showed that differences in victimization rates between ethnic minority groups and majority groups decrease or disappear when controlling for sociodemographic characteristics (e.g., Field & Caetano, 2004; Taft et al., 2009; Tartakovsky & Mezhibovsky, 2012). Some scholars suggest that both theories are supplementary rather than contradictory (Raj & Silverman, 2002; Tartakovsky & Mezhibovsky, 2012).

In a compelling review, Raj and Silverman (2002) propose future directions for practice, policy, and research on ethnic minorities. With regard to the latter aspect, the authors underscore the importance of continued study on IPV among ethnic minority groups by using representative samples. The present dissertation aimed at enlarging this research field by registering the prevalence of IPV in a population-based representative sample of Turkish ethnic minorities in Flanders. Although Belgium is often overlooked as an immigration country due to its small size and less known immigration history, immigrants comprised almost 18% of the entire population in 2010 (i.e., almost 10% without Belgian nationality) and about 30 000 naturalizations are annually allowed[2]. Today, people from Turkish (5%) and Moroccan (10%) origin form the two largest non-Western ethnic minority groups in Belgium (Levecque, Lodewycks, & Vranken, 2007; Timmerman, Vanderwaren, & Crul, 2003).

[2] http://www.migrationinformation.org/Feature/display.cfm?ID=913

Sexual minorities. One of the most recent emerging lines of research is the study of IPV among non-heterosexuals[3]. The examination of intimate violence among same-sex relationships is particularly relevant to overcome the traditional myth – based on a feminist perspective – that IPV is strictly a male-to-female concern and could not occur with similar prevalence to men who have a relationship with men and women who have a relationship with women (Potoczniak et al., 2003). In other words, this phenomenon has to be brought into the purview of family psychologists so that IPV in same-sex relationships can also be considered as common couple violence (i.e., violence in response to escalated conflict; Potoczniak et al., 2003). In an attempt to explain IPV in same-sex relationships, scholars have used two different theoretical perspectives (Burke & Follingstad, 1999). The first perspective adopts a heteronormative view on IPV to explain violence within same-sex relationships. In specific, this perspective concentrates on the dominant role of men in society and on power and control differences between women and men. Accordingly, it is suggested that violence by an intimate partner should be more prevalent in heterosexual relationships than in same-sex relationships because the latter do not experience these opposite-sex power differences (Burke & Follingstad, 1999). Indeed, evidence has been found that same-sex relationships have more egalitarian power dynamics (Schechory & Ziv, 2007). The second perspective postulates that same-sex relationships are characterized by some specific dynamics that may make them vulnerable for IPV victimization. For instance, these women and men have to cope with additional stressors such as minority stress (i.e., stress that is derived from being a member of a minority group; Meyer, 1995), which generates additional stressors in same-sex relationships. This makes them more sensitive for elevated levels of relational conflict and for IPV victimization and perpetration (Alexander, 2002; Balsam

[3] In line with Laumann, Gagnon, Michael, and Michaels (1994) this doctoral dissertation conceptualizes sexual orientation as a three dimensional construct (i.e., sexual self-identification, sexual behaviour, and sexual desire). Therefore we prefer to use the term 'non-heterosexual' rather than lesbian, gay, or bisexual (LGB). Some people might be classified as non-heterosexual even they do not identify themselves as LGB.

& Szymanski, 2005; Frost, 2011). In sum, multiple theories can be used to explain IPV in same-sex relationships, and to examine why IPV should be more/less prevalent in same-sex relationships than in heterosexual relationships.

At this time, sizable studies have already been published on IPV in same-sex relationships (for an overview see Murray & Mobley, 2009). Most of these studies predominantly focused on the prevalence of IPV within a specific sample of non-heterosexuals. Some have included a heterosexual comparison group to assess differences or similarities in IPV victimization among same-sex and heterosexual relationships. Results usually revealed that this form of violence is at least as prevalent in same-sex relationships as it is in heterosexual relationships. For instance, in a research note on IPV in same-sex relationships, Alexander (2002) reports that between 25% and 50% of the lesbian and gay intimate relationships is confronted with IPV. Murray and Mobley (2009) conclude in their methodological review that these numbers are comparable to the numbers in heterosexual relationships.

Despite the advancement of theory and research on IPV in same-sex relationships, further empirical data is needed in view of the long-term neglect of research attention to, and therefore knowledge about IPV in same-sex relationships (Burke & Follingstad, 1999; Greenwood, Relf, Huang, Pollack, Canchola, & Catania, 2002). This neglect had to do with three reasons. First, fitting in the feminist perspective mentioned above, gender role stereotypes and cultural perceptions at the societal level have contributed to an overarching myth of men as the main perpetrators and women as the main victims, which caused many researchers to focus primarily on heterosexuals (Burke & Follingstad, 1999; Eaton et al., 2008; Murray & Mobley, 2009; Seelau & Seelau, 2005). Second, IPV among non-heterosexuals has remained largely unacknowledged by the lesbian/gay communities themselves (Poorman, 2001). People in same-sex relationships may be reluctant to report IPV victimization out of fear that they will foster further stigmatization towards sexual minorities (Ard & Makadon, 2011; Eaton et al., 2008;

McClennen, 2005). Third, the focus of these communities on other themes (e.g., HIV/aids among gay men) has limited research attention on topics such as IPV in same-sex relationships (Toro-Alfonso & Rodriguez-Madera, 2004). As will be outlined later in this introduction, the present dissertation aimed at enlarging the research on the prevalence of common couple violence among both non-heterosexual women and men by means of two large-scale (representative) community samples.

Risk Markers for IPV Victimization

Given the prevalence of violence within intimate relationships, researchers have begun to look for factors that might affect the rate of IPV. These investigations are largely based on surveys in the general population, which implies that the resulting factors are particularly relevant for the understanding of common couple violence (Johnson, 2008). Although everybody is at risk to experience IPV at some time in their lives, it turns out that some people, or people in certain situations / circumstances are more likely than others to be confronted with these negative relationship experiences. Before turning to the main objectives of the present dissertation, we will shortly outline the risk markers for victimization by an intimate partner. It is important to address these markers as they have been – next to prevalence research and research on the health outcomes – a primary concern of research on IPV.

Models explaining the increased likelihood of experiencing IPV victimization have shifted from single factor models to multifactorial models (Bartholomew & Cobb, 2011). This implies that the presence of one or more risk markers will not necessarily cause IPV victimization, however, the odds of becoming a victim increases when one or more risk markers are simultaneously present (Stith, Smith, Penn, Ward, & Tritt, 2004). Heise and colleagues' (2002) ecological framework on IPV explains that intimate violence arises from an interplay between factors on four levels: The individual, relational, community

and societal level. Noteworthy is that some factors may prove to be IPV correlates while others may be considered as rather causal factors (Krug et al., 2002). Likewise, risk markers for IPV victimization correspond with risk markers for IPV perpetration. First, on the *individual* level, both biological and personal factors are included. Among these factors, young age, low education level, low income, unemployment, and alcohol use have been linked to IPV victimization and perpetration (Krug et al., 2002; Stith et al., 2004). Second, the *relationship* level refers to one's immediate social context. The most consistent risk markers on this level refer to the relationship with the intimate partner (e.g., relationship dissatisfaction, relationship separation, stalking, a history of IPV in a previous relationship), the family of origin (e.g., witnessing IPV as a child, child abuse), and social isolation (Krug et al., 2002; Stith et al., 2004; Stith, Green, Smith, & Ward, 2008). Furthermore, factors that play a role on the *community* level are related to the larger social structures in which one operates. For instance, it has been shown that poverty in the community and a lack of institutional support disproportionally increases IPV victimization and perpetration (Heise & Garcia-Moreno, 2002; Krug et al., 2002; Stith et al., 2004). Last, some factors at the *societal* level might give rise to elevated levels of IPV. It has been suggested that the acceptability of violence within a culture and social inequality between different groups within a community might contribute to higher levels of IPV (Stith et al., 2004; Heise & Garcia-Moreno, 2002).

As will be outlined in more detail within the different chapters of this dissertation, several of the above individual risk markers as well as relational correlates were taken into account in each study. To end this section on the prevalence of IPV, we address several specific caveats present in the existing literature on experiences with intimate violence.

Caveats in the Literature on IPV Prevalence Estimates

The above overview clearly indicates that violence within intimate relationships is a very complex and common social concern. This underscores the need to explore this dark side of intimate relationships in all kinds of relationships within the general population (Bradbury & Karney, 2010). Nonetheless the important steps forward that have been taken within the research field the last decades, the scientific study of IPV has been hampered by some important limitations.

First, far too many studies looked at IPV from a feminist perspective. From that point of view, IPV has been conceptualized as an almost strictly patriarchal phenomenon in which heterosexual men perpetrate physical violence against women (i.e., intimate terrorism; Strauss, 2009). Given the growing awareness of heterosexual female-to-male IPV in the context of common couple violence, population-based research should benefit from a further expansion of this knowledge by consistently taking into account both genders in community samples. Hence, in this dissertation, we will examine IPV prevalence estimates among both women and men, and explore gender differences in victimization rates. Moreover, our study of IPV in same-sex relationships will also shed light on the interplay between gender and IPV.

Second, definitional and methodological issues have limited empirical research on psychological violence for a long time (Follingstad, 2009). Indeed, very few of the aforementioned studies report on psychological violence. It should be stressed that it is very difficult to conceptualize and measure psychological IPV. Although there is a growing number of instruments to assess these acts of aggression (Woodin et al., 2013), to date, no single cohesive and universal definition exists for psychological IPV (Follingstad, 2007; McHugh, Rakowski, & Swiderski 2013; O'Leary, 2001). To summarize, psychological IPV is much more complex and subjective than physical or sexual IPV. However, accounting for some methodological considerations, this phenomenon can –

in prospect of further theoretical advancements (see Follingstad, 2007) – already be examined. Given the increasing recognition of the importance of psychological IPV, and its impact on victims' health (Woodin et al., 2013), more research is needed to examine psychological violence and how it affects women and men. Therefore, all studies within this dissertation include a range of variables – adopted from the WHO multi country study on Women's Health and Domestic Violence Against Women (Garcia-Moreno et al., 2006) – to examine to what extent women and men in our samples experience psychological violence by an intimate partner. Moreover, it will be examined how psychological violence is related to their well-being.

Third, to have a more complete picture of the phenomenon of IPV in its whole, additional research in specific populations, such as those described in previous paragraphs, must be taken into account. To this aim, we need to rely on ecologically valid samples that allow us to generalize our findings to minority populations. With regard to IPV among *ethnic* minorities, there is – compared to IPV in majority populations – to date only a small body of research that has gathered data from population-based samples within Western nations outside the U.S. (Taft et al., 2009). As this research points out that ethnic minorities might be at risk for increased IPV, it is important to further the study of these populations. In this dissertation we aimed to enlarge the literature by addressing the prevalence of IPV among an ethnic minority population by using a representative population-based sample. *Sexual* minorities can be considered a hidden group in the overall population. With regard to victimization studies among non-heterosexuals, the majority of them have used small and highly unrepresentative samples (e.g., recruited from lesbian/gay bars, social networks, clubs; Burke & Follingstad, 1999). Some studies gathered data from large-scale studies by means of widespread advertisements, but even then they were mostly based on nonrandom sampling methods (Burke & Follingstad, 1999). In other words, it is very challenging to study non-heterosexuals by means a representative sample (Balsam &

Szymanski, 2005; Burke & Follingstad, 1999; Murray & Mobley, 2009). However, representative samples are essential for confirming the external validity of a study's findings (Murray & Mobley, 2009). In this dissertation, we used a population-based sample to strive for a representative subsample of non-heterosexuals. Of course, because there is no sampling frame specific for non-heterosexuals (i.e., there are no lists of all non-heterosexuals in society), we cannot claim to be sure about the representativeness of this subsample.

Next to addressing the prevalence of intimate violence within specific samples, this dissertation aimed at enlarging the literature on the health correlates of IPV victimization. In the following paragraphs, we will discuss the potential relevance of investigating – next to individual health correlates – the relational correlates of IPV.

RELATIONAL DYNAMICS

IPV research has a long tradition of studying the *individual* health correlates of experiences with intimate violence. These victimization studies have documented the negative physical (e.g., injuries in the head, face, neck, thorax, breasts, gastrointestinal symptoms, cardiac symptoms; Campbell, 2002), sexual (e.g., sexually transmitted diseases, unwanted pregnancy or abortion; Coker, 2007) and mental (e.g., depression, post-traumatic stress disorder, anxiety problems, low self-esteem, Campbell, 2002; Johnson & Ferraro, 2000; Zlotnick, Johnson & Kohn, 2006) health correlates of IPV for victims. Although this line of research has led to considerable progress in empirical knowledge on IPV victims' well-being, some other kinds of correlates remained virtually unstudied. That is, with noted (clinical) exceptions, the research to date has not systematically clarified the link between IPV victimization and *relational* correlates within non-clinical samples.

Given the fact that relationships are intrinsically interactional, it is surprising that little empirical work has been done to examine how adverse relationship experiences influence victims' well-being in intimate relationships. As yet, relational dynamics have often been examined in the literature on relational conflict, but relatively little research reports on its association with intimate violence (Bartholomew & Cobb, 2011; Lawrence & Bradbury, 2001). To address this caveat, the current dissertation aimed to complement the existing research on how IPV victimization is associated with victims' relational as well as their sexual well-being with an intimate partner. In the following paragraphs, we will outline the theoretical background and the empirical research that has focused on the link between IPV and its relational correlates.

Theoretical Background

As already noted in the beginning of this introduction, a distinction can be made between different forms of IPV (Johnson, 1995). The present dissertation uses several representative population-based surveys. Hence, we are more likely to measure common couple violence than intimate terrorism. Consequently, the present dissertation takes the perspective that violence is the result of conflict that has gotten out of hand and is characteristic of the relationship rather than an individual characteristic. In this regard, the interpersonal schema theory may function as an overarching theoretical framework, revealing insight on why it is important to examine the relational outcomes when having experienced violence by an intimate partner.

According to this theory, a schema guides the interpersonal functioning within relationships by means of their influence on the processing of social information in interpersonal relationships. More specifically, people will seek out interpersonal relationships that confirm their schemas, and they will interpret, perceive, and behave upon new information based on previous relational experiences (Baldwin, 1992; Cloitre & Rosenberg, 2006; Hien & Ruglass, 2009). For instance, people with positive and loving

experiences within interpersonal relationships will have positive relationship schemas, which in turn will automatically enhance the probability of positive relationships in the future. In contrast, people with negative relationship experiences are at greater risk for repeated negative relationships via the development of negative relational schemas (possibly via self-fulfilling prophecy; Cloitre & Rosenberg, 2006; Hien & Ruglass, 2009). Originally, scholars have adopted this theory to explain sexual revictimization in adulthood from experiences with sexual abuse in childhood (e.g., Cloitre, Cohen, & Scarvalone, 2002). Yet, this overarching theory can also be used to explain the interpersonal functioning of IPV victims. In the following paragraphs, different theoretical models will be outlined with regard to IPV and a specific range of relational correlates.

Relational Correlates

Relationship satisfaction. According to social learning theory within intimate relationships (see Bradbury & Karney, 2010), people learn from the daily interaction patterns with their partner. Whereas positive behaviours between partners are thought to enhance the level of relationship satisfaction, negative behavioural patterns erode partners' relationship satisfaction. Consequently, it is likely that the accumulation of conflicting and violent interactions deteriorates the level of relationship satisfaction. Many studies have examined the association between IPV experiences and relationship satisfaction, relying on cross-sectional, clinical samples of women (e.g., Godbout, Dutton, Lussier, & Sabourin, 2009) and found that IPV was negatively related to victims' relationship satisfaction. Yet, intimate relationships in clinical samples – which often report the highest frequency and severity of intimate aggression – are not representative for intimate relationships in the general population (Strauss & Gelles, 1990; Williams & Frieze, 2005). Given the high prevalence of low to mild forms of

violence in intimate relationships within the general population, research should also capture the relationship satisfaction of these couples. Hence, various non-clinical studies have examined the association between IPV and victims' relationship satisfaction (e.g., Lawrence & Bradbury, 2001, 2007; Testa & Leonard, 2001; Williams & Frieze, 2005). For instance, Testa and Leonard (2001) longitudinally examined how the use of verbal and physical aggression from men to women in the first year of marriage affected their level of relationship satisfaction and, as hypothesized, found decreased levels of marital satisfaction among the women after verbal and physical IPV victimization. Simultaneously, Lawrence and Bradbury (2001) found in their longitudinal analysis evidence for increased marital dysfunction with increased levels of physical violence. Although various studies examined the IPV – relationship satisfaction link, only very few studies have used population-based samples. Furthermore, very few studies have compared this association for male and female victims (e.g., Katz, Kuffel, & Coblentz, 2002; Williams & Frieze, 2005). These two latter studies suggest that IPV victimization has more detrimental outcomes for women's relationship satisfaction than men's. Furthermore, from the research to date it is unclear whether lifetime experiences with intimate violence, which we assessed in our studies, impact on victims' current level of relationship satisfaction.

Adult Attachment. Attachment theory (Bowlby, 1969/1982, 1973) is a well-suited theoretical framework for explaining how negative relationship experiences influence the regulation of emotions, cognitions and behaviour within an intimate relationship.

Attachment research has focused mainly on the study of individual differences in attachment orientation and their impact on intra- and interpersonal processes. These individual differences can be organized along two dimensions (Brennan, Clark, & Shaver, 1998), labeled attachment anxiety and attachment avoidance. Attachment anxiety is manifested through a strong desire for closeness and intimacy to important others, and intense anxiety over rejection and abandonment. Attachment avoidance is manifested

through extreme discomfort with closeness and interdependence on important others and a strive for self-reliance (Mikulincer & Shaver, 2007). Individuals who score low on both dimensions are assumed to have a secure attachment while individuals who score high on one or both dimensions are assumed to have an insecure attachment. Traditionally, attachment orientations were considered as stable across the lifespan (Bowlby, 1969/1982, 1973; Waters, Merrick, Treboux, Crowell, & Albersheim, 2000). Yet, given the fact that people have a variety of interpersonal experiences, researchers nowadays take a more dynamic approach and assume that attachment orientations are to a certain extent adaptable (e.g., Birnbaum, Reis, Mikulincer, Gillath, & Opraz, 2006; Collins & Read, 1994; Fraley, Vicary, Brumbaugh, & Roisman, 2011). That is, changes in attachment patterns result from new – positive and negative – relationship experiences contradicting earlier relational beliefs and expectations (Fraley et al., 2011; Mikulincer & Shaver, 2007). Stated differently, attachment orientations are revised and updated in response to new relationship experiences. Hence, it is plausible to assume that experiences with high levels of distress within intimate relationships, such as IPV, increase insecure attachment orientations.

To date, most studies examining the link intimate violence – attachment have focused on attachment as a risk marker for IPV perpetration and found an association between IPV perpetration and insecure attachment (e.g., Follingstad, Bradley, Helff, & Laughlin, 2002; Fournier, et al., 2011). Viewed from this attachment perspective, IPV perpetration can be considered as an exaggerated form of protest against the attachment figure (i.e., intimate partner) by perceived real or imaginary threats of abandonment (i.e., attachment anxiety) or by an attempt to withdraw from interpersonal closeness (i.e., attachment avoidance; Mikulincer & Shaver, 2007). Studies examining IPV victimization and attachment are much more scarce. Yet, the existing studies support an association between IPV victimization and insecure attachment (Doumas, et al., 2008; Henderson, Bartholomew, & Dutton, 1997; Henderson,

Bartholomew, Trinke, & Kwong, 2005; Weston, 2008). For instance, Henderson and colleagues (1997) revealed that women who had recently left an abusive intimate relationship had significantly higher levels of insecure attachment compared to their non-clinical counterparts. Although there has been considerable research on IPV and attachment, these studies have several limitations. Next to the already noted fact that most of these studies focused on IPV perpetration, IPV victimization studies to date tended to focus on attachment in clinical samples, and partially therefore only examined men as perpetrators and women as victims (Henderson et al., 2005). In this dissertation we aimed to enlarge the literature on the link between IPV victimization – attachment among both women and men.

Sexual satisfaction and sexual functioning. As described earlier, IPV has been shown to be associated with victims' sexual health. More specifically, research supports an association between physical IPV victimization and sexual risk-taking behaviours, inconsistent condom use, partner non-monogamy, sexually transmitted diseases, unwanted pregnancies and induced abortions, pelvic pain and bleeding, and a lack of sexual pleasure among women (for a detailed overview, see Coker, 2007). Given that most people have sex within a romantic relationship, a unifying understanding of IPV victims' sexual well-being requires investigating sexual well-being both at the individual as well as relational level. However, of all relational correlates of IPV, the sexual well-being of victims within an intimate relationship has so far received the least empirical attention. Accordingly, it is not well understood how adverse sexual experiences in an intimate relationship develop out of injurious relationship experiences.

How does it come that the sexual functioning of IPV victims at the relationship level has been overlooked in theory and research? This is, at least in part, due to the fact that sex research and relationship research have evaluated in relative isolation from each other for a long time (for a detailed review see Dewitte, 2012). Today, considerable research has demonstrated that a relationship characterized by tension

and conflict evokes a decrease in sexual satisfaction and an increase of sexual dysfunction (Bodenmann, Ledermann, & Bradbury, 2007; Metz & Epstein, 2002; Stephenson & Meston, 2010). Particularly among women, relationship problems have been shown to be associated with more sexual difficulties with distress (e.g., Stephenson & Meston, 2010). It is plausible to assume that such dynamics are also at play in the context of IPV. In specific, it is likely that relationship schemas will interact with one's sexual functioning (Dewitte, 2012): A history of IPV might influence how victims generate, experience and express their (sexual) emotions. For instance, lifetime IPV victimization might lead victims to focus on self-protection and control when having sex rather than on intimacy with their partner (Metz & Epstein, 2002). In other words, they may experience their sexual functioning in a different way because they attribute different meanings to sex (Dewitte, 2012). This dissertation aimed at addressing the lack of research in this area by conducting several studies that examined the sexual well-being of people with a history of IPV. In line with Bodenmann and colleagues (2007), we refer to sexual well-being as a satisfying sexual relationship, which is characterized by satisfaction with the quality and frequency of sex, as well as by the absence of sexual dysfunctions.

Sexual communication. In addition to sexual satisfaction and sexual functioning, sexual communication is an important aspect of sexual well-being (Holmberg & Blair, 2009; Sprecher & Hendrick, 2004). Sexual communication is the process of revealing verbal information about the sexual thoughts, wishes, and needs to an intimate partner (Holmberg & Blair, 2009). Further, it has been shown to operate as a meaningful tool to develop and maintain high levels of relationship satisfaction in general (Sprecher & Hendrick, 2004) and sexual satisfaction in particular (Byers, 2005; Cupach & Metts, 1990). In this regard, the ability to communicate to the partner about what is sexually pleasing may be of vital importance (Traen & Skogerbo, 2009). An interesting framework to think about sexual communication within intimate relationships comes

from Reis and Shaver (1988). According to their intimacy process model, disclosure of intimate feelings and information of the self depends on the emotional and behavioural response of the partner to this information, as well as on how this partner's response is then interpreted. Noteworthy is that the disclosure itself is induced by one's own motives, needs, goals, and fears. Applying this model to IPV victims, it is plausible to assume that people with a history of IPV have more difficulties with discussing sexual matters with an intimate partner. In specific, IPV victims are likely to have experiences with dysfunctional, negative (general) communication patterns in their relationship (Berns, Jacobson, & Gottman, 1999). Therefore, they may be more concerned about the partner's possible emotional and behavioural reactions in response to the self-disclosure and they may be more vulnerable to negatively interpret the partner's response. Consequently, this will lead to less and impaired sexual communication. However, this is only an assumption as to date, no empirical research has provided evidence for this link. To date, most part of the research on sexual communication in the context of intimate violence has focused on the association between IPV experiences and sexual risk-taking behaviours (e.g., Testa, Zile-Tamsen, & Livingston, 2007; Wingood & Diclemente, 1997). In this dissertation, we aimed to extent the literature on the specific link between IPV victimization and sexual communication with an intimate partner. Before outlining the main research objectives, the following paragraph focuses on the role of gender in the link between IPV and its outcomes.

Gender Differences

As described earlier in this introduction, the debate is still ongoing whether or not heterosexual IPV supports a gender symmetry theory (i.e., women and men are similarly aggressive and likely to become a victim). This controversy is partially grounded in the two opposing views of family psychology theorists and feminist theorists on the motives for IPV perpetration (conflict escalation vs. coercive control; Johnson, 1995). Closely

related to this, the gender symmetry debate reflects a discussion on how IPV should be defined. That is, if intimate violence is strictly defined in behavioural terms, the notion that women and men are as likely to be a perpetrator and a victim is true, at least in the context of common couple violence. In contrast, if intimate violence is defined in terms of behaviour *and* consequences – which is correct according to the view of the feminist theorists – gender neutrality does not make much sense as there is ample evidence that women suffer greater negative consequences than men, regardless of the different types of violence (Anderson, 2002; Archer, 2000; Langhinrichsen-Rohling, 2010).

In general, studies documenting on the health correlates of intimate violence have primarily focused on female victims. However, some studies have documented the health correlates of IPV in clinical samples among both women and men and suggested that the effects are more detrimental for women (e.g., Anderson, 2002, 2005). Population-based research mainly concentrated on injuries and physical health correlates related to physical IPV. Almost all of these studies found women to have more injuries and a poorer physical health than men (Anderson, 2002; Caldwell, Swan, & Woodbrown, 2012). Mixed results are found with regard to victims' mental health correlates such as stress, depression, and anxiety: Whereas no studies found men to experience more mental problems than women, some studies found both women and men to suffer from mental difficulties and still others only found a significant effect for women (for an overview, see Caldwell et al., 2012). Even though some victimization studies assessed the impact of IPV for both women and men, only a few of them have directly compared the health correlates for male and female victims (Caldwell et al., 2012). That is, limited research has included a gender x IPV victimization interaction term and has controlled for gender as a baseline characteristic (Caldwell et al., 2012). This implies that reported gender differences in research might only display the fact that women in general are more vulnerable for mental health difficulties such as depression (e.g., Harned, 2001). By including a gender x IPV interaction term in statistical analyses,

this possibility is ruled out (Caldwell et al., 2012). Hence, the different studies reported in this dissertation consistently examined gender differences in IPV correlates by including gender x IPV victimization interactions. This brings us back to the discussion on gender symmetry in IPV. Identifying whether the health correlates of violence differ for women and men will add to the knowledge on how gender relates to the experience of IPV (Anderson, 2002). Especially in population-based samples it is imperative to examine the health correlates among both women and men because if this most gender symmetrical form of violence consistently seems to have stronger adverse relationships with the mental, relational, and sexual well-being of women than men, it is difficult to claim that IPV is not a gendered problem (Anderson, 2002, 2005).

In sum, both women and men experience adverse health correlates in response to IPV victimization. Yet, the individual correlates appear to be more detrimental for women than for men. These findings lead us to question whether gender differences also matter in the examination of relational correlates, which take a key role in the present dissertation. With regard to relationship satisfaction, research to date supports the idea that the link between IPV and relationship dissatisfaction is stronger for women than for men in population-based research (e.g., Katz et al., 2002; Williams & Frieze, 2005). A less clear association is expected with regard to the link between IPV victimization and attachment. Clinical research has demonstrated higher levels of insecure attachment among male perpetrators and female victims (Henderson et al., 1997), but, to the best of our knowledge, no such associations have been examined in the context of common couple violence. Regarding sexual communication, past research has demonstrated that women are more likely to disclose their sexual likes and dislikes than men (Byers & Demmons, 1999). Therefore, the association between IPV victimization and sexual communication might be stronger among women than men. Finally, with regard to sex, previous studies on sexual behaviour within intimate relationships have shown that sexual intimacy has a different meaning for men and

women. Whereas sexual intimacy for men implies physical sexual pleasure, and being physically close to the partner, women tend to place greater emphasis on the relationship context in their sexual behaviour including the presence of feelings of love, affection, and emotional closeness (Birnbaum et al., 2006; Schachner & Shaver, 2004; Traen & Skogerbo, 2009). Accordingly, women report more sexual difficulties when there are relationship difficulties (Bancroft, 2003; Traen & Skogerbo, 2009). Therefore, IPV might be related differently to the sexual well-being of women and men.

RESEARCH OBJECTIVES OF THE DOCTORAL DISSERTATION

The main objective of this doctoral dissertation was twofold. First, we aimed to gain more insight in the prevalence of IPV victimization – specifically, common couple violence victimization – in different populations by means of several large-scale representative population-based samples. To date, research on the prevalence of common couple violence has predominantly focused on physical aggression, directed towards heterosexual women being member of a majority population. If we want to grasp this social concern in its whole, we must take into account all populations in society, including men and minority populations. Especially because for several reasons outlined above, some minority populations have been shown to be at greater risk for IPV, including ethnic and sexual minorities. However, population-based research on IPV among minority populations is scarce. Given the growing need for additional research on IPV in minority populations, we have given special attention to the examination of IPV prevalence estimates among non-heterosexuals and people from Turkish origin. Furthermore, there is still little research focusing specifically on psychological violence. Thus, it is less known to what extent people in the general population report experiences with non-physical forms of aggression. This is unfortunate because the available literature has demonstrated that psychological violence might lead to an even

more adverse health than physical violence (e.g., Follingstad, 2007). Accordingly, we consistently assessed physical as well as psychological violence in all of our studies.

A second important aim of this doctoral dissertation was to better understand how lifetime experiences with IPV are related to victims' well-being at the relationship level. For a longtime, research has focused on the individual adverse correlates of IPV victimization. Given the interpersonal schema theory, it is logical to assume that IPV victimization relates to (later) relational experiences. However, population-based research on the relational correlates of IPV is relatively scarce. Given this empirical gap in the IPV literature, we have looked at the association between lifetime IPV experiences and victims' relational and sexual well-being within their current intimate relationship. In specific, the following correlates were examined throughout the different studies: mental well-being, relationship satisfaction, attachment, sexual satisfaction, sexual communication, and sexual dysfunction.

Research Questions and Hypotheses

Based on the two major research objectives mentioned above, the following research questions and hypotheses were tested within the different chapters of this doctoral dissertation.

Prevalence estimates. The first research question within each study concerns the prevalence of IPV victimization. More specifically, we aimed to explore to what extent (a) heterosexual women and men, (b) ethnic minority women and men and (c) non-heterosexual women and men have experienced annual and/or lifetime physical, (sexual), and psychological violence at the hands of an intimate partner. We hypothesized that across these different samples, the different forms of violence would correlate with each other and that psychological IPV would be more prevalent than physical and/or sexual violence. Several specific hypotheses were formulated with regard to differences among these different populations. First, we expected to find

higher IPV prevalence estimates in the Turkish ethnic minority population in Flanders than in the majority population in Flanders. Second, we assumed that non-heterosexuals were at least as likely as heterosexuals to report experiences with IPV. With regard to gender differences within these specific populations, the following hypotheses were formulated: In line with the available literature on common couple violence, we did not expect to find Flemish heterosexual women to report more IPV victimization than heterosexual men. In contrast, we expected the Turkish ethnic minority women in Flanders to be more likely to experience IPV than their male counterparts. Finally, no specific hypothesis was formulated regarding gender differences in non-heterosexual relationships as studies comparing lesbians and gay men in victimization rates are to our knowledge non-existent.

IPV victims' well-being. When examining IPV victims' well-being, the following hypotheses were formulated across the different populations: We predicted that higher levels of annual/lifetime physical, (sexual), as well as psychological violence would be associated with lower levels of mental health, relationship satisfaction, sexual satisfaction, and sexual communication. Additionally, we expected to find increased levels of insecure attachment orientations and sexual dysfunction. Finally, we aimed to explore potential gender differences in the link between IPV victimization and victims' well-being. We have to be very careful with making predictions as only limited research explored the role of gender in victims' (relational and sexual) well-being, but the following hypotheses were formulated: Although we expected the associations to be stronger for women than for men, we assumed that both victimized women and men would report a decrease in mental health, relationship satisfaction, sexual satisfaction, and sexual communication and an increase of insecure attachment orientations and sexual dysfunctions. Below, we give a brief overview of the different chapters within this dissertation (see Table 1).

Chapter Overview

In the first empirical study, *Chapter 2*, we examined the extent to which adult women and men have experienced physical, psychological, and sexual IPV in the past 12 months by a current partner in Belgium. Since the last two representative population-based studies on (intimate partner) violence date from 1989 (Vandewege, Bruynooghe, & Opdebeeck, 1989) and from 1998 (Bruynooghe, Nolanders, & Opdebeeck, 1998), there was a lack of up-to-date prevalence estimates of IPV in Belgium. Next to the provision of advanced prevalence estimates, we analyzed the relationship between IPV victimization, mental health, and relationship satisfaction among both female and male IPV victims. Data of 1472 respondents were analyzed.

Chapter 3 extends the previous chapter in several ways. First, this study examined lifetime prevalence estimates for physical and psychological IPV victimization among heterosexual women and men in Flanders (*N* = 1448) by means of a representative population-based sample. This sample was part of a survey "Sexual health in Flanders" (i.e., Sexpert; Buysse et al., 2013). Advanced count regression models – specifically designed to analyze skewed counts or rates (e.g., Atkins & Gallop, 2007; Karaszia & van Dulmen, 2010) – were used to explore gender differences and the role of sociodemographic risk markers of IPV victimization. Second, we examined, next to victims' mental well-being, how lifetime IPV victimization impacts on victims' relationship satisfaction and attachment orientation in their current partner relationship and explored the association between IPV and victims' sexual well-being in terms of sexual satisfaction, sexual communication, and sexual dysfunction. Gender differences in these individual and relational IPV correlates were discussed.

Chapter 4 specifically reports on IPV among Turkish ethnic minorities. This study used data from a representative population-based sample of 392 Turkish ethnic minority women and men in Flanders. This sample was part of a subsample of the Sexpert study, namely "Sexual health among ethnic minorities in Flanders". In line with the two main

objectives of this doctoral dissertation – and similar to the research design of Chapter 3 – this study explored lifetime prevalence estimates for physical and psychological IPV victimization among women and men from Turkish origin. Next, this study evaluated how IPV victimization affects these Turkish respondents' current mental, relational, and sexual well-being.

The main focus of *Chapter 5* was IPV among non-heterosexuals. Lately, there is a growing interest in IPV in non-heterosexual intimate romantic relationships (see Alexander, 2002; Murray & Mobley, 2009). In this study, we aimed to extend this emerging line of research by examining the prevalence of IPV among non-heterosexuals, by analyzing potential differences/similarities in prevalence estimates between heterosexuals and non-heterosexuals, and by exploring differences/similarities in prevalence estimates between non-heterosexual women and non-heterosexual men. Furthermore, this study explored how IPV victimization is related to non-heterosexual victims' mental and sexual well-being. An important limitation of previous research is that most studies have used small or large convenience samples that make it difficult to generalize the findings (Balsam & Szymanski, 2005; Murray & Mobley, 2009). To answer our research questions, this study used data from two samples (i.e., a representative population-based sample, N = 1571 heterosexuals & N = 119 non-heterosexuals and a large-scale convenience sample, N = 2401 non-heterosexuals). Whereas the first sample was part of the Sexpert survey on sexual health in Flanders, the second sample reported on a subsample of a follow-up study on the sexual health of non-heterosexuals.

Finally, *Chapter 6* comprises a general discussion and presents an integrated overview of the main findings from the different studies. The limitations and strengths of our studies are considered. Implications for clinical practice, suggestions for future research and policy recommendations on intimate partner violence are finally, outlined.

It should be noted that the present dissertation consists of several papers, which are in press, under editorial review, or have been submitted for publication. Given that

each of the papers should be able to stand on its own, the text of some of the chapters may partially overlap.

Table 1. Overview of the Different Studies Examining (a) IPV Prevalence Estimates and (b) Victims' Mental, Relational, and Sexual Well-Being

	Chapter 2	**Chapter 3**	**Chapter 4**	**Chapter 5**
Prevalence IPV	Physical Psychological Sexual 12 months	Physical Psychological Lifetime	Physical Psychological Lifetime	Physical Psychological Lifetime
Individual well-being	Mental health	Mental health	Mental health	Mental health
Relational well-being	Relationship satisfaction	Relationship satisfaction Adult attachment style	Relationship satisfaction Adult attachment style	
Sexual well-being		Sexual satisfaction Sexual dysfunction Sexual communication	Sexual satisfaction Sexual dysfunction Sexual communication	Sexual satisfaction Sexual dysfunction
N	1472 Belgian respondents	1448 Flemish respondents	392 Turkish respondents	1571 heterosexuals and 119 non-heterosexuals (sample I) 2401 non-heterosexuals (sample II)
Sample type	Representative	Representative	Representative	Representative (sample I) Convenience (sample II)

Note. IPV = intimate partner violence.

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CHAPTER 2

INTIMATE PARTNER VIOLENCE IN BELGIUM: PREVALENCE, INDIVIDUAL HEALTH OUTCOMES AND RELATIONAL CORRELATES[1]

ABSTRACT

Research on intimate partner violence (IPV) using national samples is important to guide prevention efforts. However, the latest prevalence estimates for Belgium date from more than ten years ago. Therefore, this study used population-based cross-sectional data (*N* = 1472) to assess to what extent adult women and men in Belgium experienced psychological, physical or sexual violence from their current partner in the last year. Next to assessing the association with individual health correlates, we explored the association between IPV and relationship satisfaction. The annual prevalence of physical IPV in a current relationship was 1.3%. Only women experienced sexual IPV (0.3%). Fourteen percent of the respondents reported psychological violence and no differences were noted between women and men. Victims of psychological IPV reported adverse mental health outcomes and the effect was stronger for women than for men. Additionally, psychological victimization was associated with a diminished level of relationship satisfaction, but no gender differences were noted.

[1] Based on Hellemans, S., Buysse, A., De Smet O., & Wietzker, A. (in press). Intimate partner violence in Belgium: Prevalence, individual health outcomes, and relational correlates. *Psychologica Belgica*.

INTRODUCTION

The last decades, there has been an intensification of research on intimate partner violence (IPV) at both international as well as national levels[2]. Specifically in Belgium, two large representative population-based studies have already been conducted on IPV. The first study dates from 1988 and only analyzed violence against women (Vandewege, Bruynooghe, & Opdebeeck, 1988). The second study was extended to men (Bruynooghe, Nolanders, & Opdebeeck, 1998). As the most recent prevalence rates date from more than ten years ago, the major aim of the current study was to provide up-to-date national IPV prevalence estimates. In addition, this study further expands the knowledge on two topics that have only recently gained more research attention. These include the involvement of men as victims, which still remains a controversial research topic, and the examination of psychological IPV. Alongside registering the occurrence of IPV, we aimed to examine both the individual and relational well-being among IPV victims.

Prevalence Research on Intimate Partner Violence

The World Health Organization (WHO, 2010) refers to IPV as "behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours" (p.11). Paradoxical to the idea of romantic relationships, an intimate partner does not always offer love and security. A substantial percentage of people incur the risk of experiencing violent acts from their partner at least once in their lifetime (e.g., Archer,

[2]See the UN Secretary-General's database on violence against women for an overview of country studies: http://sgdatabase.unwomen.org/country.action.

2000; Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006). However, partially due to large methodological differences between studies, the exact magnitude of the problem is difficult to grasp. For instance, prevalence rates strikingly depend on how IPV is defined (i.e., the forms of IPV included in the definition), to who the study is addressed (i.e., clinical samples vs. community samples), and on the timeframe that is used (i.e., lifetime vs. year prevalence). Therefore, methodological aspects have always to be kept in mind when interpreting IPV estimates.

Sample choice. Studies on IPV have been conducted in a variety of samples, which can be categorized as clinical samples (i.e., a risk group for IPV victimization/perpetration) or community samples (i.e., a random sample of the general population or a convenience sample based on availability). There is clear evidence that community samples generate lower prevalence rates than clinical samples, which indicates that the latter samples rather measure severe IPV victimization while community samples mainly measure mild and moderate violence (Anderson, 2005; Krahé, Bieneck, & Möller, 2005). Nevertheless, even within community samples studies report great variations in prevalence estimates. For instance, the population-based study of the WHO (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002) in 48 countries reported annual prevalence rates of physical IPV in women ranging from 3% to 52%. An American population-based study (Breiding, Black, & Ryan, 2008) disclosed annual prevalence rates of physical and/or sexual IPV of 1.4% in women and 0.7% in men. In 2005, Krahé and colleagues specifically discussed the prevalence of physical and/or sexual IPV in 35 studies from 21 countries outside the U.S. These scholars report estimates for women's physical IPV victimization ranging from 2.7% to 52% and from 7% to 76.9% for sexual victimization. Twelve of these studies also provided prevalence rates for male physical victimization that ranged from 4.1% to 19%. A national IPV prevalence study in France (Jaspard et al., 2002) reported annual prevalence rates for women's psychological (8%), physical (2.5%), and sexual (0.9%) victimization. Despite the aforementioned

methodological variations between studies, ongoing knowledge on IPV in national samples stays very valuable to guide prevention and intervention efforts (Breiding et al., 2008). In this respect, the present study aimed to provide recent prevalence estimates of IPV in a nationally representative sample of Belgian women and men.

Gender. Although great progress has been made in terms of how to define, assess and address violence within relationships, the debate on gender and IPV is still ongoing (Afifi et al., 2009; Johnson & Ferraro, 2000; Woodin, Sotskov, & O'Leary, 2013). Some scholars refer to gender as a key factor in IPV, while others view gender as only rather one of the components of the problem (Woodin et al., 2013). When it comes to empirical research findings, mixed results are found in terms of gender (a)symmetries. Some studies report higher physical victimization rates for women, some report similar rates for women and men and some report higher physical victimization rates for men (see Krahé et al., 2005 for a detailed review). A meta-analysis on gender differences in aggression between heterosexual partners (Archer, 2000) found gender symmetry in physical IPV among community samples but found men to be mostly be the perpetrators in samples selected for severe victimization. The idea of gender (a)symmetry in the violence literature can be situated in two theoretical perspectives that have debated the etiology of IPV, namely the "feminist perspective" and the "family violence perspective" (Johnson, 1995; Johnson & Ferraro, 2000). The feminist perspective posits that IPV is a direct outcome of men using severe and multiple forms of violence such as terrorization and threats to control their partner (i.e., intimate terrorism). In this perspective, men are predominantly the perpetrators and women the victims of IPV (Dobash, Dobash, Wilson, & Daly, 1992). The family violence perspective refers to more moderate forms of partner violence and hypothesizes that violence is used to address conflict rather than to control the partner (i.e., common couple violence). According to this perspective, women are just as likely as men to be perpetrators or victims of IPV (Prospero, 2008a). It is assumed that community samples rather measure common couple violence, while

clinical samples rather measure intimate terrorism (Johnson, 1995). Based on the fact that the current study reports on a general, representative community sample, we first hypothesized that no or small gender differences would be found in IPV prevalence rates (H1).

Psychological IPV. Recently, there is an increasing recognition of the importance of examining psychological violence. Psychological IPV or psychological aggression is by Follingstad (2009) referred to as "the full range of potentially negative intimate interpersonal behaviours, without implying that all aggression is abusive" (p. 272). This latter aspect in the sentence is important as to date there is no consensus about this construct. Neither a universal description has been established for psychological IPV, nor a legal definition (Follingstad, 2007). Scholars differ in what to call the acts of non-physical forms of violence (McHugh, Rakowski, & Swiderski, 2013), and there is no general cut-off score to determine whether or not one is a victim of psychological intimate violence (O'Leary, 2001). In other words, psychological IPV is much more subjective, and therefore more complex to measure and to understand than physical IPV. When examining psychological violence, one must keep in mind these conceptual difficulties as they influence the results (Follingstad, 2009).

Notwithstanding these aforementioned difficulties, recent studies have noted the importance of integrating psychological aggression in IPV research as it is more prevalent, often a precursor of physical IPV, and may be more harmful than physical IPV (Follingstad, 2007; Follingstad & Edmundson, 2010; Krug et al, 2002; Péloquin, Lafontaine, & Brassard, 2011; Romans, Forte, Cohen, Du Mont, & Hyman, 2007). Therefore, we hypothesized that in the present study psychological violence would also be more prevalent than both physical and sexual IPV (H2).

Individual Well-Being

Experiences with IPV undermine the individual well-being of victims (e.g., Afifi et al., 2009). Surveys focusing on the health correlates of IPV victimization among both women and men have suggested that there may be substantial differences in how they experience these violent acts, despite equivalent experiences with IPV (Anderson, 2002). Indeed, a robust finding in these studies is that the health outcomes for victimized women are more adverse than for men (Anderson, 2005; Archer, 2000; Swan & Snow, 2003; Williams & Frieze, 2005). Overall, studies have shown that in the context of heterosexual domestic violence, women are much more likely than men to report physical injuries (e.g., chronic pain syndrome, cuts and bruises, stress-related symptoms; Archer, 2000; Campbell, 2002) and mental health problems (e.g., poor self-reported health, depression, anxiety, alcohol and drug abuse, feelings such as anger, guilt, shame, and personal distress; Anderson, 2005; Campbell, 2002; Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008; Foa, Cascardi, Zoellner, & Feeny, 2000; Follingstad, 2009; Johnson & Ferraro, 2000; Zlotnick, Johnson , & Kohn, 2006; Williams & Frieze, 2005). A potential explanation for this effect is that violence directed from women to men is in general less frightening than violence directed from men to women (Swan & Snow, 2003). However, Afifi et al. (2009) found an association between a poor mental health and physical IPV for both men and women, although gender differences were noted. That is, men reported more externalizing problems (e.g., substance abuse) and women more internalizing problems (e.g., anxiety disorders) as reaction to their victimization.

Only a limited number of studies have addressed the health effects of psychological violence in intimate relationships. As already stated, no general consensus exists on how psychological violence should be defined and which acts it should contain (Follingstad, 2007). Nevertheless, evidence has been found that psychological violence has a negative health impact (Coker et al., 2002) with depressive symptoms and decreased self-esteem as the best documented health outcomes for psychological IPV

(Follingstad, 2009). As research on the association between psychological IPV and health outcomes in men is scarce, it still remains unclear whether the effects of psychological IPV are equal for men and women. We presumed that – in line with the overall literature on the health outcomes of IPV experiences – exposure to IPV would be associated with a poorer mental well-being in both men and women (H3a) and that this effect would be stronger for women (H3b).

Relational Well-Being

Most studies on IPV have investigated the impact on the victim rather than on the quality of the relationship. Indeed, researchers (e.g., Follingstad, 2009) agree that the relationship as a system that changes due to aversive interpersonal actions has not received a lot of attention in the IPV research. The link between violence within relationships and diminished relationship satisfaction is rather assumed than empirically investigated (Bradbury, Fincham, & Beach, 2000). It is difficult to know whether low relationship satisfaction leads to IPV and thus functions as a "risk marker", or whether lowered satisfaction is the result of IPV. Stith, Smith, Penn, Ward, and Tritt (2004) identified low levels of relationship satisfaction as one of the most important risk markers for IPV, whereas the longitudinal study of Testa and Leonard (2001) found evidence for decreased relationship satisfaction in women *following* IPV. In addition, a stronger association was found between relationship satisfaction and IPV for female victims than for male victims (Stith et al., 2004). However, these findings are difficult to generalize because many studies of violent couples have focused on those who are in marital therapy and who thus already report more marital distress (Williams & Frieze, 2005). To counter this limitation, Williams and Frieze (2005) investigated the relationship between violent relationships and relationship satisfaction in a national sample of women and men and similarly found that female victims of physical IPV

experienced greater detriment to their relationship satisfaction than male victims (regardless of the severity of IPV).

Studies on the link between IPV and relationship functioning have some important limitations. First, they predominantly focus on violence directed from men to women. Consequently, less is known about the link between relationship satisfaction and IPV for victimized men (Stith et al., 2004). Furthermore, research addressing the link between relationship satisfaction and IPV has mainly focused on physical abuse. Little is known about the perception of relationship satisfaction in the context of psychological IPV and the existing results are mixed (Follingstad, Rogers & Duvall, 2012). For these reasons, we aimed to examine the link between IPV and relationship satisfaction among male and female victims of IPV. In line with the representative sample of Williams and Frieze (2005), we expected to find that IPV victims would report less relationship satisfaction (H4a) and that this effect would be stronger for women than for men (H4b).

METHOD

Participants and Procedure

This study made use of a subsample of a population-based cross-sectional survey on interpersonal violence in Belgium, entitled "Emotional, physical and sexual abuse – the experiences of women and men" (Pieters, Italiano, Offermans, & Hellemans, 2010). This survey contained information on violence in the public sphere, family violence, IPV and sexual violence. Data were collected between April and July 2009. Our study samples were a priori stratified based on language (i.e., Dutch, French), region (i.e., Flanders, Wallonia, Brussels), gender (i.e., women and men), and age (i.e., between 18 and 75 years of age) to make them representative of the Belgian population. A sample of 5037 individuals was recruited through WDM Belgium, a marketing service provider

specialized in gathering data and database management service[3]. Once the sample frame was set up, all selected individuals received a recruitment letter with a brief description of the study and an invitation to participate. The survey was presented as "A survey of health, safety and general living conditions". The actual interview was conducted by telephone. In order to increase the response rate, each absent individual was contacted at least five times in different time periods (e.g., hours, days). Women were contacted by female interviewers and men by male ones to make sure that respondents would feel at ease with answering sensitive questions. All interviewers – master students in psychology or sociology – were carefully trained by the researchers. That is, they were given training on the quality and validity of data collection by survey, on the questionnaire and the contact procedure, and on the topic of this survey "interpersonal violence". Of the total sample, 613 persons were excluded because of death (*n* = 4), illness (*n* = 85), language issues (*n* = 120), age (*n* = 203), long term absence (e.g., abroad for a long period; *n* = 39), or a wrong number or relocation (*n* = 162). This resulted in 4424 eligible interviews. There were 2351 active and passive (i.e., unable to contact after five phone attempts) refusals. A full survey was completed by 2073 individuals (response rate: 47.03% of the eligible respondents). After cleaning the data for missing values, the final dataset consisted of 2014 respondents (94.5% Belgian nationality; 1211 Flemish and 803 French speakers). After data collection, the data were weighted by age. Comparisons with the adult Belgian population, provided by the Directorate-General for Statistics and Economic Information Statbel (2008), indicated no meaningful differences between the study sample and the Belgian population on the gender of the respondents (women: $49.3\%_{sample,}$ $51.1\%_{population}$; men: $50.7\%_{sample,}$ $48.9\%_{population}$) and region (Flanders: $60.8\%_{sample,}$ $57.9\%_{population}$; Wallonia: $32.0\%_{sample,}$ $32.6\%_{population}$, and Brussels: $7.3\%_{sample,}$ $9.5\%_{population}$).

[3] WDM Belgium is now active under the name 'Bisnode'. For a detailed overview how Bisnode gathers and manages data, we refer the reader to www.bisnode.be

Because this study reports on respondents' experiences with IPV in their current relationship we used data from 1472 respondents who were in a relationship at the time of the survey (45.8% women and 54.2% men). The mean age of the women was 42.26 years (*SD* = 14.41, Range: 18-75). The mean age of the men was 47.46 years (*SD* = 14.85, Range: 18-75). More than two-thirds (68.3%) were married, 15.4% were single, 11.4% were cohabiting, 3.9% were divorced and 1.1% were widowed. Most of the respondents (76.3%) had one or more children. Among the respondents, 4.6% had no degree or a primary school degree, 45.8% had finished secondary school, 34.5% had earned a high secondary school degree, and 49.6% had earned a high school degree.

Measures

Sociodemographics. In addition to gender, age, education level, and civil status, respondents were asked about their area of residence (i.e., a big city, suburbs of a big city, small town, or a village), how often they participate in outside activities, how often they meet and talk to friends and family members (both answers ranging from 0 = *never* to 4 = *daily or almost daily*), and whether they experience the frequency of these contacts as satisfactory (0 = *yes, enough* or 1 = *no, not enough*).

Intimate partner violence. In the current study, IPV was conceptualized as self-reported physical, psychological and sexual victimization by the current partner in the past 12 months. More specifically, respondents were asked "Thinking about your partner, would you say that over the past 12 months he/she…" followed by a number of concrete terms measuring the different indicators of IPV. In line with the national survey on violence against women in France (Jaspard et al., 2002), physical IPV was assessed by five items based on the Conflict Tactics Scale (Straus, 1979): (a) thrown something at you, shaken you or grabbed you suddenly, (b) scratched you, bitten you or pulled your hair, (c) slapped you, punched or kicked you, hit you with something that hurts, (d) threatened you with a weapon, a dangerous object, or attempted to kill you or

strangle you, and (e) prevented you from entering home, locked you out or when in the car, left you by the roadside. Respondents answered whether or not (0 = *no* and 1 = *yes*) they had experienced each incident and if so, how many times in the past 12 months this happened to them (ranging from 1 = *once* to 4 = *daily or almost*). We recoded the five items such that they ranged from 0 (= *no)* to 4 (= *daily or almost daily)*. A final score for physical IPV was computed by summing the scores for each item (Range: 0 – 20). The Cronbach's alpha reliability for this scale was .69.

Psychological IPV was assessed with an adapted version of the Multidimensional Measure of Emotional Abuse (MMEA; Murphy & Hoover, 2001). This original 28-item scale comprises four subscales. In the present study, we selected – in line with Jaspard et al. (2002) – five items divided over the four different subscales: (a) restrictive engulfment (e.g., "tried to limit the contact with your friends or family members"; "insisted on knowing with whom and where you are"), (b) denigration (e.g., "has sworn at you, criticized or ridiculed you for what you were doing or saying"), (c) hostile withdrawal (e.g., "has stopped talking to you, totally refused to discuss things with you") and (d) dominance/intimidation (e.g., "did something to intimidate you such as screaming, breaking objects, threatening to kill you or threatening to commit suicide"). Respondents answered whether or not (0 = *no* and 1 = *yes*) they had experienced each incident and if so, how many times in the past 12 months this had happened to them (ranging from 1 = *rarely* to 4 = *systematically*). We recoded these five items such that they ranged from 0 (= *no*) to 4 *(= systematically)*. A final score for psychological IPV was computed by summing the scores for each item (Range: 0 – 20). Cronbach's alpha was .73 for this scale.

As a measure of sexual IPV, respondents were asked two questions (items modified from the national survey on violence against women in France, Jaspard et al., 2002): "Thinking about your partner, would you say that over the past 12 months he/she (a) forced you to carry out sexual acts that you found degrading or humiliating?" and (b)

"forced you to undergo sexual touching, or attempted or succeeded to have sex with you against your will?" Respondents indicated if they had experienced these incidents (0 = *no* and 1 = *yes*), and if so how often they had experienced them in the past 12 months (ranging from 1 = *once* to 4 = *daily or almost daily*). We recoded both items such that they ranged from 0 *(= no)* to 4 *(= daily or almost daily).* A final score for sexual IPV was computed by summing the scores for the two items (Range: 0 -8)[4].

Individual well-being. Respondents' individual well-being was assessed with six single items. These were selected on the basis of other international population surveys on interpersonal violence (see Pieters et al., 2010 for a detailed overview of these studies). First, respondents' self-perceived general health was assessed with the question "Would you say that, overall, your health is...?" with answers ranging from 0 (= *very good*) to 4 (= *very bad)*. Second, respondents' daily stress level was assessed using the question "Thinking about the level of stress in your life, would you say that most days are..?". Answers ranged from 0 (= *not at all stressful*) to 4 (= *very stressful*). Third, sleeping problems in the past 12 months were assessed with the question "How often have you had trouble falling asleep or staying asleep?" with answers ranging from 0 (= *never*) to 4 (= *all the time*). Fourth, the question assessed respondents' alcohol use "How often do you drink alcohol?" with answers ranging from 0 (= *never*) to 4 (= *daily or almost daily).* Fifth, respondents were asked whether they had suffered from serious depression or from chronic anxiety in the past 12 months (0 = *no* and 1 = *yes*). Finally, a suicide attempt was assessed with the question "Have you ever attempted suicide?" (0 = *no* and 1 = *yes*). All the items described above were used in the analyses separately.

Relational well-being. The Revised Dyadic Adjustment Scale (DAS-16; Antoine, Christophe, & Nandrino, 2008) is a 16-item self-reported evaluation of relationship adjustment. The original scale (DAS-32; Spanier, 1976) comprises four subscales (i.e., consensus, satisfaction, cohesion, and affective expression). In the revised version, a

[4] Note. No Cronbach alpha was calculated for the sexual IPV scale as only two items were included.

two-dimensional approach is used: (a) the degree of agreement (10 items; e.g., "To what extent do you and your partner generally agree about objectives, goals that are considered important in life?") and (b) the quality of dyadic interactions (6 items; e.g., "I confide in my partner."). Respondents' answers ranged from 0 (= *never agree*) to 5 (= *always agree*). The sum score is a measure of the overall relationship satisfaction with higher scores indicating more positive adjustment (Range: 0 – 80). In this study, Cronbach's alpha for the total DAS score was .81.

Analyses

Analyses were run in SPSS 20.0. We used a weighting variable based on the variable age because respondents in the older age category (i.e., 65 to 75 years) were overrepresented and respondents in the younger age categories (i.e., 18 to 34 years) were underrepresented in our study than would be expected by coincidence. By using a weighing variable, the answers of younger people weigh more in the statistical analyses and the answers of older people weigh less such that the results are in line of what could be expected based on the general population. Bivariate statistics (Pearson chi-square test and independent sample t-tests) were calculated to explore the link between the previously mentioned sociodemographic characteristics and IPV experiences. A series of multiple regression analyses were performed to determine the role of psychological IPV in predicting victims' individual and relational well-being.

RESULTS

Prevalence of Physical, Psychological and Sexual IPV

Table 1 shows the descriptive statistics of our main study variables and Table 2 provides an overview of the descriptives and frequencies of the different acts of IPV. Overall, 14.0% (*n* = 206) of the respondents had experienced at least one act of psychological violence by their current partner in the past 12 months. Physical IPV was reported by 1.3% of the respondents (*n* = 19) and 0.3% of the respondents (*n* = 5) reported sexual IPV in the past 12 months. The overall frequencies of psychological IPV ranged from 0 to 16, of physical IPV from 0 to 9 and of sexual IPV from 0 to 2 (see Table 1).

Table 1. Descriptive Statistics of the Study Variables

Variable	*N*	*M(SD)*	*Min*	*Max*
Psychological IPV	1472	.46 (1.53)	0.00	16.00
Physical IPV	1469	.03 (.33)	0.00	9.00
Sexual IPV	1472	.01 (.10)	0.00	2.00
Self-perceived general health	1471	.98 (.80)	0.00	4.00
Stress level	1471	1.96 (1.09)	0.00	4.00
Sleeping problems	1472	1.07 (1.20)	0.00	4.00
Alcohol use	1472	1.66 (1.31)	0.00	4.00
Relationship satisfaction	1471	44.96 (8.69)	2.00	64.00
Anxiety/Depression	1471	yes = 5.1%		
Suicide attempt	1471	yes = 2.1%		

Note. IPV = intimate partner violence.

Table 2 indicates that the most prevalent acts of psychological IPV included being criticized or ridiculed for what [you] were doing or saying and that [your] partner stopped talking and refused to discuss things with [you]. The most prevalent act of physical IPV was that the partner had thrown something at [you] or shaken or grabbed

[you]. As hypothesized (cf. H2), psychological IPV was much more prevalent than both other forms of IPV. Notwithstanding the small amount of reported physical and sexual violence, a significant correlation was found between the three different forms of IPV ($r_{physical\ IPV\ and\ psychological\ IPV} = .26$, $p < .01$; $r_{sexual\ IPV\ and\ psychological\ IPV} = .32$, $p < .01$; $r_{physical\ IPV\ and\ sexual\ IPV} = .25$, $p < .01$). With regard to gender, sexual violence was only reported by women and no significant differences were found between women and men for both physical, $t(1339.03) = 1.62$, $p = .11$, and psychological IPV, $t(1336.93) = 1.80$, $p = .07$. This indicates that women and men were equally likely to be exposed to physical and psychological violence by their current partner in the past 12 months. Because of the low numbers of respondents reporting sexual and physical IPV, cautiousness regarding the interpretation of these findings is warranted and generalization is limited. Therefore, in the further analyses, we only included data of respondents who have exclusively experienced psychological IPV in the past 12 months from their current partner ($n = 189$; 14.0% of the women and 12.3% of the men).

Sociodemographic characteristics of IPV. When examining the sociodemographic characteristics of respondents reporting psychological IPV (see Table 3), results revealed no significant effect of education level, area of residence, and age. An effect was found for civil state: Both single (22.3% vs. 14.1%) as well as divorced respondents (6.9% vs. 3.4%) were more likely to report psychological IPV, compared to the other groups. Furthermore, no association was found between psychological violence and both the frequency of social activities and the frequency of social contact with friends or family. In contrast, a significant effect was found for the perception of having sufficient contact with family/friends: Among the respondents who reported not having sufficient contact with family or friends, there were more respondents reporting psychological violence (17.6% vs. 11.8%).

Table 2. Descriptive Statistics and Frequencies of IPV Victimization in the Past 12 Months

IPV	*M(SD)*	*%*
Psychological IPV	.46 (1.53)	14.0
Tried to limit the contact you have with your friend(s) or family members	.07 (.40)	3.0
Insisted on knowing with whom and where you were	.12 (.53)	5.5
Sworn at you, criticized you or ridiculed you for what you were doing or saying	.12 (.49)	6.7
Stopped talking to you, totally refused to discuss things with you	.11 (.46)	5.9
Did something to intimidate you (e.g., screaming, breaking objects, threatening to kill you or threatening to commit suicide)	.05 (.31)	2.8
Physical IPV	.03 (.33)	1.3
Thrown something at you, shaken you or grabbed you suddenly	.02 (.17)	1.1
Scratched you, pinched you, bitten you or pulled your hair	.00 (.07)	0.4
Slapped you, punched or kicked you, hit you with something that hurt you	.01 (.10)	0.4
Threatened you with a weapon, a dangerous object or attempted to kill you or strangle you	.00 (.05)	0.1
Prevented you from entering your home, locked you up, locked you out, or when in the car, left you by the roadside	.00 (.04)	0.2
Sexual IPV	.01 (.10)	0.3
Forced you to carry out sexual acts that you found degrading or humiliating	.00 (.07)	0.2
Forced you to undergo sexual touching, attempted or succeeded, by force, to have sex with you against your will	.00 (.07)	0.1

Note. IPV = intimate partner violence.

Table 3. Sociodemographic Characteristics of Respondents Reporting Psychological IPV by their Current Partner in the Past 12 Months

Variable	*M(SD)*	*Test of difference*	*Effect size*
Education level	-	$\chi^2(1) = .00$	*Phi* = .00
Area of residence	-	$\chi^2(4) = 4.55$	*V* = .06
Civil status	-	$\chi^2(4) = 17.70$***	*V* = .11
Perception social contact	-	$\chi^2(1) = 4.99$*	*Phi* = .06
Age	45.17 (14.81)	*t*(1446) = .89	*d* = -.07
Frequency of social activities	2.24 (1.16)	*t*(1444) = -1.78	*d* = .15
Frequency of social contact	3.13 (.78)	*t*(1437) = 1.04	*d* =.08

Note. IPV = intimate partner violence.

** p <*.05. *** p <*.001.

Psychological IPV and Individual Well-Being

Four separate hierarchical linear regressions were used to examine the effect of psychological victimization on respondents' self-perceived general health, daily stress level, sleeping problems, and alcohol use, while controlling for the possible socio-demographic characteristics gender, age and education level. Results are presented in Table 4. The test results showed a significant detrimental effect of psychological IPV on general health, $F(5,1427) = 27.65$, $p < .001$, on daily stress level, $F(5,1426) = 26.00$, $p < .001$, and on sleeping problems, $F(5,1426) = 19.78$, $p < .001$. No effect was found for the use of alcohol. Furthermore, results revealed two significant interactions with gender, namely for general health and daily stress level. To examine the nature of these interactions, we computed the correlations between psychological victimization and both variables separately for women and men. A significant correlation was found between psychological IPV and general health for women ($r = .14$, $p < .01$) but not for the men. Similarly, where a significant correlation was found between psychological IPV and daily stress level for women ($r = .10$, $p < .01$), no correlation was found for men.

Suffering from anxiety or depression and suicide attempt are dichotomous categorical variables. To assess the effect of psychological victimization on these health outcomes, two binary logistic regression models were calculated (see Table 4). Respondents reporting higher levels of psychological victimization were more likely to report that they suffered from anxiety or depression in the past 12 months, $\chi^2(5) = 11.65$, $p = .04$. No significant interaction with gender was found. Differently, psychological IPV was not associated with suicide attempt, $\chi^2(5) = 10.10$, $p = .07$: Women and men reporting psychological victimization were not more likely to ever report a suicide attempt compared to their non-victimized counterparts. To conclude (cf. H3a and H3b), psychological IPV by the current partner in the past 12 months affects victims' individual well-being, with some differences noted between women and men: Both women and men report more sleeping problems, and more anxiety or depression but only women perceive their general health as less well and experience higher levels of daily stress.

Table 4. Summary of Hierarchical Multiple Regression Analyses and Binary Logistic Regression Analyses Examining the Effect of Psychological IPV on Victims' Individual Well-Being

	General health			Stress level			Sleeping problems			Alcohol use			Depression/anxiety			Suicide		
	B	*SE B*	β	*B*	*SE B*	β	*B*	*SE B*	β	*B*	*SE B*	β	*B*	*SE B*	Exp(B)	*B*	*SE B*	Exp(B)
Gender	-.07	.04	-.04	-.22***	.06	-.10	-.49***	.07	-.20	-.72***	.07	-.27	-.41	.26	.67	-.63	.41	.53
Age	.01***	.00	.22	-.01***	.00	-.19	.01***	.00	.14	-.01***	.00	-.09	.01	.01	1.01	.01	.01	1.01
Educational level	-.25***	.04	-.16	.28***	.06	.13	.04	.06	.02	-.37***	.07	-.14	-.15	.25	.86	-.71	.41	.49
Psychological IPV	.15**	.05	.26	.17**	.07	.22	.16*	.07	.19	-.10	.08	-.10	.56*	.29	1.76	.27	.28	1.32
Gender x Psychological IPV	-.08**	.03	-.22	-.09*	.04	-.18	-.05	.04	-.09	.04	.05	.06	-.38	.25	.69	-.11	.20	.90
Total R^2		.09***			.08***			.07***			.11							
Nagelkerke R														.03**			.04**	
n		1433			1432			1432			1433			1436			1436	

Note. IPV =intimate partner violence.

*** p <.001.** p< .01. * p<.05.

Psychological IPV and Relationship Satisfaction

Finally, a hierarchical linear regression analysis was used to test whether relationship satisfaction could be predicted by respondents' experiences with psychological violence (view Table 5). To control for possible effects of socio-demographic characteristics (i.e., gender, age, education level), these variables were entered in the first step. In the second step, respondents' scores for psychological IPV were entered and in the third step, the gender and psychological IPV interaction term were added to the model. Overall, the model was found to be significant and accounted for 11% of the variance in relationship satisfaction, $F(5, 1427) = 35.60$, $p < .001$. Higher levels of psychological victimization corresponded with lower scores on the dyadic adjustment scale, indicating less relationship satisfaction. According to the insignificant interaction term both women and men reporting higher levels of psychological IPV by their current partner in the past 12 months evaluated the quality of their relationship as less well.

Table 5. Summary of Hierarchical Regression Analysis to predict Relationship Satisfaction from Psychological IPV

	Relationship satisfaction	
	ΔR^2	β
Step 1	.02***	
Gender		-.03
Age		-.09***
Educational level		.08**
Step 2	.09***	
Psychological IPV		-.38***
Step 3	.00	
Gender x Psychological IPV		.08
Total R^2	.11***	
n	1432	

Note. IPV = intimate partner violence.
** p* <.05. *** p* < .01. **** p* <.001.

DISCUSSION

The present study describes the prevalence of physical, sexual as well as psychological violence by an intimate partner. Using a nationally representative sample of the Belgian population, up-to-date victimization rates for both women and men were tested. This study additionally explored the association between IPV victimization and victims' individual and relational well-being.

These most recent prevalence estimates in the overall sample indicate that about one out of seven respondents reported psychological violence by their current partner in the last year. Physical violence by the current partner was reported by 1.3%. Sexual violence (0.3%) was only reported by female respondents. As in other prevalence studies on IPV (e.g., Marshall & Hultzworth-Monroe, 2002), this latter form is much less prevalent than physical and psychological IPV. Our Belgian findings are in line with the annual physical and sexual IPV prevalence rates of the U.S. population-based survey (Breiding et al., 2008), yet, they are lower than the general annual IPV prevalence estimates published in the review of Krahé and colleagues (2005), which rely on different sampling and survey methods. More specifically, Krahé et al. (2005) included – next to representative samples – clinical and convenience samples which clearly lifted up the prevalence estimates whereas this study only reports on a representative sample, which have been found to detect lower estimates compared to other sorts of samples (Nielsen & Einarsen, 2008). Furthermore, except for the elevated levels of psychological IPV in the present study, our findings are in line with the French national representative survey (Jaspard et al., 2002) measuring IPV in an almost identical way as the present study. Our elevated levels for psychological IPV might be explained by the fact that the French study only reports on women aged 20-59 years old.

This study supports the more recent literature suggesting that violence by an intimate partner is not strictly a male-to-female phenomenon but a human

phenomenon (Carmo, Grams, & Magalhaes 2011; Cho, 2012; Péloquin et al., 2011; Swan & Snow, 2003). That women and men in the present study report equal levels of psychological and (physical) IPV is at first sight deviant from the majority of research on IPV victimization. However, when considering the methodological context of the study, similar findings have been provided by other scholars (e.g., Archer, 2000). Concretely, previous studies on IPV in representative samples also showed little differences in prevalence estimates between women and men fitting the perspective that family researchers use to approach IPV. This perspective assumes that representative samples measure moderate and gender-balanced violence within couples (i.e., 'common couple violence') that is rather used to address conflict than to control the partner. This meaning of our findings on gender symmetry can only be formulated as an assumption because as in most other national surveys on IPV - we did not measure controlling behaviours (Anderson, 2005; Williams & Frieze, 2005) that would provide evidence for IPV as approached from a feminist perspective. The latter perspective refers to severe IPV victimization specifically driven by threats and control (i.e. 'intimate terrorism'), is more gender asymmetrical and is mainly captured in clinical samples.

With regard to sexual IPV, only women reported sexual victimization by an intimate partner in the past 12 months. Sexual aggression by an intimate partner might be more common than all other forms of sexual aggression (Marshall & Hultzworth-Monroe, 2002) and actual prevalence rates might in fact be higher than reported in the current study as it is usually one of the most difficult forms of IPV to reveal.

This study's findings concerning the sociodeomographic characteristics that might affect IPV victimization, revealed significant associations with respondents' civil status as well as with respondents' subjective experiences of social contact with family and friends. More specifically, respondents being officially single or divorced were more likely to report psychological victimization. This is consistent with other studies (Campbell, 2002; Coker et al., 2002) and suggests that for some people, this is a

vulnerable period in which they might hanker after a new stable relationship that increases the possibility to make a "wrong" partner choice and to get involved in a violent relationship. Furthermore, the literature describes the presence of a social network as an important protection factor in the limitation of victimization. From our findings, it became clear that there is no association between the frequency of social activities and IPV victimization. Neither does the frequency of social contact with family and friends had a link with violence by an intimate partner. The subjective experience of these social contacts, however, was linked to the occurrence of psychological violence. Therefore, the idea can be urged that victims' require more contact with family or friends than they actually have – for instance because their violent partner forces them to remain silent – which in turn leads to more dissatisfaction about these contacts. Furthermore, concerning the role of gender and education level, inconsistent findings are reported in the overall literature (Krahé et al., 2005; Stith et al., 2004). This study showed that psychological violence affected all respondents, regardless of their age or education level.

Our examination of the mental well-being of respondents reporting psychological IPV shows that psychological victimization in the past year is related to diminished mental health outcomes. Overall, victimized respondents report more sleeping problems and signs of depression or anxiety. Only female victims perceived their general health as less well and reported higher daily stress levels. These findings lead us to three interesting conclusions. First, it shows that psychological violence – in absence of physical and sexual IPV – has a clear negative impact on the recipient. Second, considering the relatively low frequencies of psychological violence, it demonstrates that even mild and moderate levels of psychological violence can have an influence on one's mental well-being. Last, it provides evidence that – although women suffered more than men in this study – male victims also suffer from the negative effects of psychological IPV victimization. Taken together, these results are in line with the

existing evidence that psychological IPV can be as damaging as physical IPV in terms of mental health outcomes (Capeza & Arriaga, 2010). Additionally, they suggest that psychological IPV victimization deserves further study among both women and men.

Most research on the link between IPV and relationship satisfaction has been conducted in clinical samples and in female victims of physical IPV. It is assumed that there is a stronger link between relationship (dis)satisfaction and IPV in clinical samples than in community samples as couples in marital therapy already report more marital distress (Williams & Frieze, 2005). However, this study also provides evidence for an association between psychological IPV and a diminished relationship satisfaction in a community sample of women and men. This indicates that relationship dissatisfaction is not only reported in the context of severe physical abuse, but also in the context of moderate forms of psychological IPV. This is in line with some previous research that has shown that even more subtle forms of psychological abuse can be linked with a variety of negative adjustment-related variables, psychological distress, and marital dissatisfaction (Williams & Frieze, 2005).

Strengths, Limitations, and Implications

The present study reports on a large-scale representative sample of the Belgian population, including both female and male respondents from Flanders and Wallonia. A surplus value of this study is that prevalence rates were provided for psychological IPV. In general, reviews on the prevalence (Krahé et al., 2005) as well as on the health outcomes of IPV (Coker et al., 2002) only discuss studies that focused on physical and sexual IPV because of the small number of studies on psychological violence.

Several limitations of the study need to be addressed. First, our prevalence rates are relatively low, which suggests an underestimation of the actual prevalence rates. This is probably due to both methodological and thematic barriers. For instance, the present study is a telephone survey, which limited surveying people without a fixed

telephone such as young people (who nowadays are more likely to use only cell phones) and people not living in a stable household residence. Yet, evidence exists that these groups are at greater risk to experience IPV victimization (Stith et al., 2004). In addition, many people dislike being phoned up by marketing agencies or researchers to complete surveys. Because only assertive people dare to withdraw from telephone surveys, this might have led to a selection bias. Furthermore, as this is a survey on a sensitive topic, respondents may have been reluctant to disclose IPV experiences due to feelings of shame and fear of revenge. This lack of disclosure would be more prominent in male victims than in female victims (Carmo et al., 2011).

Second, although the use of a representative community sample allowed us to gather information on the occurrence of violence within the general population, it has to be kept in mind that our sampling strategy probably elucidated only a part of the problem. As aforementioned, different types of samples tend to capture different types of IPV with victims of severe forms of intimate physical aggression being systematically excluded from community samples opposed to clinical samples (Johnson, 1995). In this respect, we believe that both community and clinical samples are necessary to grasp IPV in its entirety and that both minor and severe violence should be addressed in research in order to reduce the prevalence of IPV (Strauss, 2009).

Third, as in most other IPV studies, the cross-sectional nature of this study indicates that our findings should merely be interpreted in terms of associations. In this respect, longitudinal designs are needed to help us to clarify the causal directions of our findings and to better understand the relational processes by which intimate relationships change over time.

Fourth, a limitation of our population research on IPV was that the data were very skewed towards zero, which has implications for the power of our statistical analyses. Although this sample design provides us authentic descriptive IPV information and generates findings that are applicable to the overall population, it limited us to test

individual and relational correlates for physical and sexual IPV because of the small cell accounts. When examining the health correlates of IPV in depth, future studies would benefit from using specific victims samples rather than representative samples. Fifth, this study design unfortunately put restrictions on the number of items that could be included in the survey. Therefore, only single items were used to measure individual health correlates. Standardized measures of these constructs would have been more methodologically sound to capture the mental health status of the respondents. Nevertheless, the short version of the Dyadic Adjustment Scale, which we used to examine relationship satisfaction is a valid and reliable instrument with a high degree of internal consistency.

In sum, we presented up-to-date prevalence estimates for the different forms of IPV and found no or small gender differences in the prevalence rates. Psychological IPV was more prevalent than both physical and sexual IPV, and the latter form was only reported by women. Furthermore, psychological IPV was associated with a poorer mental well-being among both women and men, but this effect was stronger for women. Last, higher levels of psychological victimization corresponded with a devaluation of respondents' relationship satisfaction and no gender differences were found. Despite the above-mentioned limitations of population-based research, we believe in the importance of an ongoing investment in large-scale representative surveys on violence within intimate relationships because of its implications for a national policy on IPV: It allows us to address recommendations to policy-makers, and to public and private institutions who seek to advance the prevention of violence. In our opinion, future studies would benefit from the development of a standardized instrument to measure IPV as such that with every new conducted national survey, comparisons can be made with earlier prevalence rates and that the effectiveness of both prevention and intervention strategies can be evaluated. Specifically for sexual IPV, future studies would benefit from exploring a broader range of sexually coercive behaviours within the

relationship. This study, as most studies (Marshall & Hultzworth-Monroe, 2002), predominantly focused on the use of force while sexual violence also occurs in the form of non-physical acts such as for instance being naked against your will or watching sexual images against your will.

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CHAPTER 3

INTIMATE PARTNER VIOLENCE VICTIMIZATION: PREVALENCE AND VICTIMS' RELATIONAL AND SEXUAL WELL-BEING[1]

ABSTRACT

Existing research shows that experiences with intimate partner violence (IPV) harm victims' individual well-being. Surprisingly, little is known about how IPV experiences might impact on victims' well-being at the relationship level. This study examined how lifetime experiences with physical and psychological violence are associated with victims' current relational and sexual well-being in a large scale population-based study in Flanders (*N* = 1448). Our results show that 10.0% of the population was confronted with physical violence and 56.7% with psychological violence. As predicted, higher levels of IPV victimization corresponded with a poorer mental well-being, higher levels of attachment anxiety and attachment avoidance, and decreased levels of relationship satisfaction. Furthermore, victims reported decreased levels of sexual satisfaction, more difficulties with sexual communication and elevated levels of sexual difficulties with distress. Whereas no gender differences were found for victims' sexual well-being, the effect of IPV on victims' mental and relational well-being was more pronounced among women than men in our study.

[1] Based on Hellemans, S., Loeys, T., Dewitte, M., De Smet, O., & Buysse, A. (2013). *Intimate partner violence victimization: Prevalence and victims' relational and sexual well-being.* Manuscript submitted for publication.

INTRODUCTION

Intimate partner violence (IPV) refers to "behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours" (WHO, 2010, p. 11). Different theoretical perspectives have debated the etiology of violence within intimate relationships, called "the feminist perspective" and "the family violence perspective". According to Johnson (1995) and Johnson and Ferraro (2000), these two theoretical perspectives refer to distinct types of IPV, which they, respectively, labeled "intimate terrorism" and "common couple violence". Intimate terrorism tends to be used to control the intimate partner and contains severe forms of aggression. It embodies a systematic strategy to intimidate the partner and is related to psychopathological perpetrator characteristics. Differently, common couple violence tends to be used to control a stressful conflict escalation in the course of the relationship, consists of mild to severe forms of violence, and is associated with disturbed relationship dynamics (Carlson & Jones, 2010; Johnson, 1995). Johnson (1995) further argues that data collected from clinical samples is likely to measure intimate terrorism and that community samples mainly measure common couple violence.

World-wide high prevalence rates of this complex and multifaceted phenomenon have led scholars to examine the individual health correlates associated with experienced IPV. No unique set of symptoms can be considered as definitely characteristic of IPV victimization but clear evidence has been provided that experiences with IPV harm the physical, mental, and sexual health of victims (e.g., Campbell, 2002; Coker et al., 2002; Follingstad, 2009). Although this line of research has revealed important information about the health outcomes of IPV, the study of physical and

psychological violence within relationships could certainly benefit from more research taking an interpersonal perspective. Yet, at this point, there is only limited research examining the effect of experiences with IPV on victims' intimate partner relationships. Therefore, the aim of the present study was to build on and expand previous research in this area by addressing the effects of lifetime IPV victimization on victims' current relational as well as their sexual well-being.

IPV and Relational Well-Being

Relationships are intrinsically interactional and the everyday exchanges between two partners influence the affective and cognitive perceptions people have on intimate relationships (Bartholomew & Cobb, 2011; Bradbury & Karney, 2010; McNulty & Karney, 2001). In this vein, it is logic to assume that experiences with violence by an intimate partner affect victims' relational well-being. Drawing from social learning theory within intimate relationships (SLT; see Bradbury & Karney, 2010) and attachment theory (Bowlby, 1969/1973, 1982), we outline below how IPV experiences might impact on victims' relationship satisfaction and adult attachment orientation.

Relationship satisfaction. The SLT is a meaningful theory to understand how adverse relationship experiences may lead to adverse feelings about that relationship (see Bradbury & Karney, 2010). Specifically, this model posits that one's relationship satisfaction is largely determined by a couples' positive and negative interaction patterns. A sequence of positive interactions enhances relationship satisfaction, while the accumulation of unresolved conflicting and violent interactions erode satisfying feelings about the relationship (Lawrence & Bradbury, 2007). The association between the presence of IPV victimization and less relationship satisfaction has repeatedly been illustrated (e.g., Fournier, Brassard, & Shaver, 2011; Godbout, Dutton, Lussier, & Sabourin, 2009; Katz, Kuffel, & Coblentz, 2002; Testa & Leonard, 2001). Still, the

question whether IPV victimization takes a toll on the level of relationship satisfaction is more complex than one would expect (Lawrence & Bradbury, 2007). For instance, Williams and Frieze (2005) revealed that about one fourth of the respondents reporting mutually mild to high levels of violent behaviours still characterized their intimate relationship as excellent. Additionally, Follingstad and colleagues (2012) revealed that the more a woman believed she contributed to her partner's use of psychological violence, the higher her score on relationship satisfaction. It thus seems that violent acts are perceived as less harmful for the relationship when both partners are violent (see also Anderson, 2002; Follingstad, Rogers, & Duvall, 2012; Williams & Frieze, 2005). Although research in general found that higher levels of IPV victimization corresponded with lower levels of relationship satisfaction (for a review, see Stith, Green, Smith, & Ward, 2008), variations across studies underscore the importance of further investigation. Moreover, it is not known whether lifetime experience with IPV impacts on the current level of relationship satisfaction.

Adult attachment orientation. From another perspective, attachment theory clearly explains how negative relationship experiences influence the regulation of emotions, cognitions, and behaviour within intimate relationships (Mikulincer & Shaver, 2007). Throughout the years, a two-dimensional approach to determine individual differences in attachment orientation has been favored (e.g., Brennan, Clark, & Shaver, 1998). The anxiety dimension denotes the extent to which individuals strive for closeness and proximity, worry about rejection and abandonment, and feel distressed when significant others are unavailable or unresponsive. The avoidance dimension reflects the extent to which individuals avoid closeness and relational intimacy, remain emotionally independent, and strive for self-reliance. Individuals who score low on both dimensions are perceived as securely attached individuals, whereas individuals scoring high on one or both dimensions are perceived as insecurely attached. There is research demonstrating stability in attachment orientations throughout life (Collins & Read, 1994)

as well as evidence showing that attachment orientations are to some degree changeable as they influence and are influenced by relationship experiences. Stated differently, the latter perspective implies that attachment orientations are subject to revision and are updated in response to new relationship experiences (Birnbaum, Reis, Mikulincer, Gillath, & Opraz, 2006; Collins & Read, 1994; Fraley, Vicary, Brumbaugh, & Roisman, 2011).

The paradoxical fact that an intimate partner can be a comforting figure as well as a source of distress stimulated researchers to examine how IPV is related to people's attachment orientation. During times of distress in intimate relationships – such as IPV – negative emotions are activated, which in turn activate the attachment system (Ainsworth, Blehar, Waters, & Wall, 1978). People behave in ways that are conform to their attachment-related beliefs and expectations. It is therefore not surprising that IPV is related to elevated levels of insecure attachment. In line with theory, a series of studies have found an association between insecure attachment orientations and IPV perpetration (e.g., Allison, Barthlomew, Mayseless, & Dutton, 2008; Babcock, Jacobson, Gottman, & Yerington, 2000; Fournier, Brassard, & Shaver 2011). Furthermore, it may be that lifetime experiences with IPV victimization have a negative effect on attachment orientation by increasing insecure attachment. Specifically, lifetime IPV victimization might affect the way victims perceive and interpret cognitions, emotions and behaviour within future intimate relationships (e.g., Weston, 2008).

IPV and Sexual Well-Being

Studies examining the health correlates of IPV have consistently found an adverse effect on victims' sexual well-being (Campbell, 2002; Coker et al., 2002). To date, there is evidence that (physical) IPV victimization is associated with increased prevalence of sexual risk-taking behaviours, which in turn leads to an increased risk of sexually

transmitted diseases, more unwanted pregnancies and abortions, an increased likelihood of dyspareunia, and a lack of sexual pleasure (for an overview, see Coker 2007). Yet, at this point, it has remained unstudied how lifetime IPV experiences might undermine victims' current sexual well-being and sexual communication at the relationship level.

Sexual satisfaction and sexual dysfunction. In this study, sexual well-being is referred to as a satisfying sexual relationship, characterized by satisfaction with the quality and frequency of sex and by the absence of sexual dysfunction (Bodenmann, Ledermann, & Bradbury, 2007). Recently, a growing body of research has been produced that demonstrates the important role of the relational context in understanding the different aspects of couples' sexual well-being. For instance, various studies have shown that relationship problems are associated with a decline in sexual satisfaction (e.g., Sprecher & Cate, 2004) and — especially among women — with sexual dysfunctions and sexual distress (Bodenmann et al., 2007; King, Holt, & Nazareth, 2007; Stephenson & Meston, 2010). Given this strong interdependence between sex and intimate relationships, it is plausible to assume that lifetime experiences with tensed and discordant relationships, characterized by negative affect and negative behavioural patterns in the relationship, interfere with current positive sexual interactions.

Sexual communication. Sexual communication refers to the interpersonal verbal communication of one's sexual thoughts, feelings, and needs (Holmberg & Blair, 2009; Traen & Skogerbo, 2009). The extent and quality of (sexual) communication within a relationship are often considered as important determinants of the overall relationship satisfaction and the level of intimacy between partners (Greeff & Malherbe, 2001). In addition, research has shown that intimate communication is associated with the quality of the sexual relationship between partners (e.g., Cupach & Comstock, 1990; Montesi et al., 2013). Thus, when discussing the association between adverse relationship experiences and victims' current sexual well-being it is also highly interesting to have a

clearer view on the interactional processes between partners such as sexual communication. Yet, studies examining the link between IPV victimization and sexual communication as a function of maintaining a satisfying sexual relationship with the partner are non-existent. Since the ability to communicate in a sexual context is related to sexual risk-taking behaviours (e.g., Testa, Zile-Tamsen, & Livingston, 2007), and since people are more likely to disclose their sexual likes when they have positive relationship schemas (Byers & Demmons, 1999), it is expected that lifetime IPV experiences also diminish the extent to which a victim is likely to discuss their sexual needs and desires with their current partner.

The Present Study

This study adds to the IPV literature by taking into account several thematic limitations of previous research. First, this study specifically addresses victims' relational and sexual well-being – besides their mental well-being that traditionally received the most research attention – using a large-scale representative sample. Although previous studies have used community samples, studies examining victims' relational well-being in the context of IPV have mainly used dating (e.g., Follingstad, Bradley, Helff, & Laughlin, 2002) or clinical samples (e.g., Rhatigan & Axsom, 2006), limiting the generalizability of the existing findings on the IPV – relational well-being link. Next to IPV victims' mental and relational well-being, this study examines IPV victims' sexual well-being in their intimate relationships, which has only rarely been studied. Second, this study informs about how intimate violence might impact male victims. As previous community samples revealed women and men to be equally likely the victims of intimate violence (Archer, 2000), it is important to examine how IPV affects both genders' mental, relational and sexual well-being (Stith et al., 2008). Third, this study enlarges the existing knowledge on IPV by specifically examining the effects of

psychological victimization. Only recently, scholars expanded the IPV research with the investigation of psychological violence and these studies revealed that psychological aggression may account for a greater impact on victims' individual and relational well-being than physical IPV (e.g., Bartholomew & Cobb, 2011; Coker et al., 2002).

Related to the previous points, the overall aims of the present study were (a) to examine the lifetime experiences of women and men with physical and psychological IPV (RQ1), and (b) to investigate the effects of lifetime physical and psychological IPV victimization on respondents' current mental well-being as well as their relational and sexual well-being in the relationship with their partner (RQ2). In line with prior research on IPV in community samples, we hypothesized that neither for physical (H1a) nor for psychological (H1b) IPV gender differences would be found in lifetime victimization rates. Furthermore, we hypothesized that increased levels of lifetime physical and psychological IPV victimization would correspond with lower mental health scores (H2a and 2b), less relationship satisfaction (H3a and 3b), more anxious (H4a and 4b) and avoidant (H5a and 5b) attachment orientations, decreased levels of sexual satisfaction (H6a and 6b) and sexual communication (H7a and 7b) and increased levels of sexual dysfunction (H8a and 8b). Potential differences between women and men were examined as evidence has been found that IPV victimization might affect the well-being (e.g., Anderson, 2002; Williams & Frieze, 2005) of both genders differently.

METHOD

Participants and Procedure

This sample drew on data from the survey "Sexual Health in Flanders" (Buysse et al., 2013), a large-scale representative survey on sexuality, sexual health and relationships in Flanders. The survey contained extensive information on sexual health

characteristics and biomedical, psychological, demographic, and socio-cultural correlates. Data were collected between February 2011 and January 2012 and respondents between 14 and 80 years of age were included. Our final sample consisted of 1832 respondents (response rate: 40.0% of the eligible respondents), who were randomly drawn from the Belgian National Register. The sample was stratified by age (aged 14 to 25, 26 to 49, and 50 to 80). Data were gathered via face-to-face interviews, along with a combination of computer-assisted personal interviewing (CAPI) and computer-assisted self-interviewing (CASI). More specifically, all sensitive information (i.e., a wide range of sexual health characteristics) was gathered in a CASI set-up, so that respondents never had to share private information about their sexual health with an interviewer. In this study, we report on a subsample of the total sample, namely on adult (≥ 18 years) heterosexual women and men with both parents having the Belgian nationality[2] (*N* = 1448). The mean age of the women (*n* = 694) was 46.87 years (*SD* = 16.88, Range: 18–79). The mean age of the men (*n* = 754) was 45.99 years (*SD* = 16.38 , Range: 18–80). Most women (79.8%) and men (83.2%) were in a romantic relationship. Among the respondents, 4.5% were still studying, 29.9% held no degree or a secondary school degree, 35.4% had earned a high secondary school degree, 20.2% held a bachelor degree, and 10.0% had earned a higher level university degree.

Measures

Sociodemographic characteristics. Next to their age, education level and relationship status, respondents were asked about sociodemographic characteristics that have been identified as risk factors that strongly relate to IPV victimization (see Stith, Smith, Ward, & Tritt, 2004). These included how often they meet family (0 = *never in the past six months* to 7 = *daily or almost daily*), or friends (0 = *never in the past six*

[2] A specific population-based survey "Sexual Health of Ethnic Minorities in Flanders" was used to examine IPV victimization among non-Western, ethnic minorities in Flanders (i.e., Turkish and Moroccan descents).

months to 7 = *daily or almost daily*) at home or elsewhere, how important religion is (1 = *very unimportant* to 5 = *very important*), whether their family income is above 2000 euros (1 = *no* and 2 = *yes*), and whether they perceived this family income as sufficient to live comfortable (1 = *very uncomfortable* to 7 = *very comfortable*). Additionally, five questions assessed the extent of social support (e.g., "There are several people I can go to for a chat when I feel lonely.") on a 5–point Likert scale (from 1 = *totally disagree* to 5 = *totally agree*). A score for social support was computed by summing the scores on each item (α = .73).

Intimate partner violence. In the present study, lifetime IPV is defined as self-reported experiences of physical or psychological violence at the hands of a current or former partner. Physical IPV was assessed with one question measuring different acts of physical aggression (adapted from the Conflict Tactics Scale, CTS; Straus, 1979). Respondents were asked "If you think about your current or former partner, has he/she ever hit you with the flat of their hand, hit you with their fist, kicked you, or physically hurt you in another way?". This question was rated on a 5-point Likert scale (from 0 = *never* to 4 = *very often*).

To assess psychological IPV, we adopted and modified items from the WHO Multi-country Study on Women's Health and Domestic Violence against Women (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005). Respondents were asked "If you think about your current or former partner, has he/she ever..." (a) tried to limit the contact you have with your friends or family members, (b) insisted on knowing your whereabouts and who you were with at every moment of the day, (c) ignored you or treated you indifferently, (d) criticized you or ridiculed you for what you do or say, (e) belittled or humiliated you in front of other people, (f) intentionally done something to scare or intimidate you, and (g) threatened to hurt you or someone you love. These seven items were rated on a 5-point Likert scale (from 0 = *never* to 4 = *very often*). The total scale score for psychological violence was computed by summing the scores for

each item, with a higher score indicating more severe psychological IPV (Range: 0-28). The seven items proved to be internally consistent (α = .87).

Mental health. Respondents' current mental health was assessed using the MHI-5, a five-item short version of the 18-item Mental Health Inventory (MHI; Veit & Ware, 1983). All items (e.g., "During the past four weeks, how much of the time were you a happy person?") were scored on a 6-point Likert scale (from 0 = *never* to 5 = *all the time*). Higher scores were indicative for a better mental well-being (Range: 0-25). The alpha reliability for the MHI-5 in this study was .82.

Relationship satisfaction and sexual satisfaction. Respondents' relationship and sexual satisfaction with their current partner was assessed using the Maudsley Marital Questionnaire (MMQ; Arrindell, Boelens, & Lambert, 1983; Crowe, 1978). The original scale consists of 25 items and yields three subscales. Given the focus of this study, only the relationship satisfaction (e.g., "Regardless of sex, how satisfied are you about the life with your partner?") and the sexual satisfaction (e.g., "How much do you enjoy having sex with your partner?") scales were used. All items were rated on a 9-point Likert scale (from 0 = *very satisfied* to 8 = *very unsatisfied*). Scores for relationship satisfaction (Range: 0 – 80) and for sexual satisfaction (Range: 0-40) were computed by summing the scores of all items in each scale. Higher scores corresponded with more relationship dissatisfaction and more sexual dissatisfaction. The 10-item measure for relationship satisfaction (α = .91) and the five-item measure for sexual satisfaction (α = .80) were reliable in the present study.

Adult attachment orientation. Individual differences in attachment orientations in their current intimate relationship were assessed with the Experiences in Close Relationships Scale-Short Form (ECR-S; Wei, Russell, Mallinckrodt, & Vogel, 2007; Dutch version by Conradi, Gerlsma, van Duijn, & de Jonge, 2006). The ECR-S compromises two scales, attachment anxiety and attachment avoidance. On a 5-point Likert scale (from 1 = *totally not agree* to 5 = *very agree*), respondents scored six anxious items (e.g., "I

worry that my partner won't care about me as much as I care about him/her.") and six avoidant attachment items (e.g., "I am nervous when my partner gets too close to me."). Higher scores reflected greater anxious or avoidant attachment. The Cronbach's alpha reliabilities were .55 for attachment anxiety and .68 for attachment avoidance. Dropping one or more items did not significantly increase the internal consistency of the subscales.

Sexual communication. A four-item short version of the 13-item Dyadic Sexual Communication Questionnaire (DSC; Catania, 1986) was used to assess sexual communication with the current partner. All items (e.g., "Do you find some sexual matters too difficult to discuss with your partner?") were rated on a 5-point Likert scale (from 1 = *never* to 5 = *almost always or always*). A scale for sexual communication was computed by summing the scores for all items (Range: 4-20). A higher score indicated more difficulties with communicating on a sexual topic. The four-item measure was reliable in the present study (α = .73).

Sexual function and sexual distress. The Sexual Functioning Scale (SFS; Enzlin et al., 2012) was used to examine impaired sexual function and sexual distress associated with impaired sexual function. The SFS covers a range of sexual problems such as increased or decreased spontaneous/responsive sexual desire, arousal dysfunction, orgasmic dysfunction, dyspareunia, vaginismus, retrograde ejaculation, and lack of a forceful propulsive ejaculation. All sexual difficulties (e.g., "In the past six months, did you have the feeling that you had a decreased interest in sex, in sexual activities or decreased sexual fantasies or erotic thoughts?") were rated on a 4-point scale (ranging from 1 = *no* to 4 = *severe or extreme*). In order to determine the clinical significance of these sexual difficulties, respondents who had scores of ≥ 2 on any of these items were asked to evaluate how distressing each sexual difficulty was. That is, they were asked to what extent they experienced this sexual difficulty as a source of distress for themselves, for their partner, and for their relationship. Each type of distress was scored 1 (= *no or*

mild distress), 2 (= *moderate distress*) or 3 (= *severe or extreme distress*). Distress was considered to be present if they had a sum score of ≥ 5 (i.e., moderate levels of distress in at least two of three domains, namely personal distress, partner distress or relational distress). For this study, a sexual dysfunction scale was computed (0 = *no dysfunction*, 1= *one or more sexual difficulties without distress,* 2 = *one or more sexual difficulties with distress*).

RESULTS

Prevalence of Intimate Partner Violence

Descriptive statistics and correlations are provided in Table 1. Overall, 10.0% of the respondents reported at least one experience with physical IPV (RQ1). Lifetime psychological IPV was reported by 56.7% of the respondents with – as shown in Table 2 – "being criticized or ridiculed for what [you] do or say" as the most frequently reported act and "threats made to hurt a loved one" as the least prevalent act. According to the overall frequencies, respondents reported on average low counts of physical and psychological IPV victimization (Table 1). As theoretically expected, a strong correlation was found between both forms of aggression (r = .54, p < .001). Furthermore, both lifetime physical and psychological IPV were significantly correlated with all outcome variables (i.e., mental health, relationship dissatisfaction, attachment orientations, sexual dissatisfaction and sexual communication; see Table 1).

Table 1. Descriptive Statistics and Pearson Correlations of the Main Variables

Variable	*N*	*M (SD)*	*Min*	*Max*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
Physical IPV	1427	.14 (.46)	0.00	4.00	.54**	-.16**	.35**	.11**	.13**	.13**	.10**
Psychological IPV	1422	2.69 (4.07)	0.00	28.00	-	-.19**	.62**	.27**	.34**	.26**	.25**
Mental health	1445	19.26 (3.83)	4.00	25.00		-	-.35**	-.24**	-.15**	-.25**	-.13**
Relationship dissatisfaction	1149	12.37 (11.85)	0.00	70.00			-	.41**	.57**	.56**	.45**
Anxious attachment	1135	2.52 (.70)	1.00	4.83				-	.33**	.28**	.24**
Avoidant attachment	1133	1.95 (.67)	1.00	4.67					-	.36**	.46**
Sexual dissatisfaction	1115	9.17 (7.80)	0.00	39.00						-	.50**
Sexual communication	1079	8.89 (3.65)	4.00	20.00							-
Sexual dysfunctions	1060	No = 61.6%, without distress = 20.2%, with distress = 18.2%									

Note. IPV = intimate partner violence.

** $p < .01$.

Table 2. Descriptive Statistics and Frequencies of Lifetime IPV Victimization

Physical IPV	*M (SD)*	*%*
Hit you with the flat of their hand, with their fist, kicked you or physically hurt you in another way	.14 (.46)	10.0%
Psychological IPV	2.69 (4.07)	56.7%
Tried to restrict your contact with family and friends	.36 (.77)	21.9%
Insisted upon knowing your whereabouts every moment of the day	.63 (.10)	35.7%
Ignored you and treated you indifferently	.51 (.84)	33.7%
Criticized you or ridiculed you for what you do or say	.58 (.88)	38.2%
Belittled or humiliated you in front of other people	.38 (.77)	25.6%
Intentionally done something to scare or intimidate you	.15 (.55)	9.4%
Threatened to hurt either you or someone you love	.10 (.51)	5.3%

Note. IPV = intimate partner violence.

Sociodemographic characteristics of IPV victimization. As illustrated in Figures 1 and 2, physical and psychological IPV victimization are not normally distributed in this sample. To analyze the effect of gender (H1a and H1b) and the aforementioned sociodemographic characteristics on IPV victimization (i.e., the dependent variables), we used count models that are specifically designed to analyze (right) skewed counts. Several models have been developed for analyzing count data such as the Poisson regression or the Negative Binomial regression (NB) when the data is overdispersed (i.e., variance is larger than the mean; see Atkins & Gallop, 2007; Karazsia & van Dulmen, 2010). Because count data often display a lot of zero observations, extended versions of these models were developed such as the Poisson logit hurdle model and the Negative Binomial logit hurdle model (NBLH; for a detailed explanation, see Loeys, Moerkerke, De Smet, & Buysse, 2012). These models split the distribution in zero-counts (i.e., zero-hurdle part) and non-zero counts (i.e., counts part). The zero-hurdle part is a binary

logistic regression and examines the effect of a predictor (e.g., gender) on the *likelihood* of experiencing IPV, while the counts part examines the effect of a predictor on the *frequency* of IPV experiences specifically among victims. In both parts, regression coefficients are exponentiated (e^B) and called odds ratios (*ORs*) and rate ratios (*RRs*), respectively. When expressed in percentages, 100 x (e^B – 1), *ORs* indicate the percentage decrease or increase in the odds of experiencing IPV, whereas *RRs* indicate the percentage of decrease or increase in the expected frequency of IPV experiences for every unit increase in the predictor variable, while holding all other variables in the model constant. Graphs and statistical tests (see Atkins & Gallop, 2007; Loeys et al., 2012) showed that the NB model yielded the best fit for physical IPV (Figure 1) and the NBLH model for psychological IPV (Figure 2).

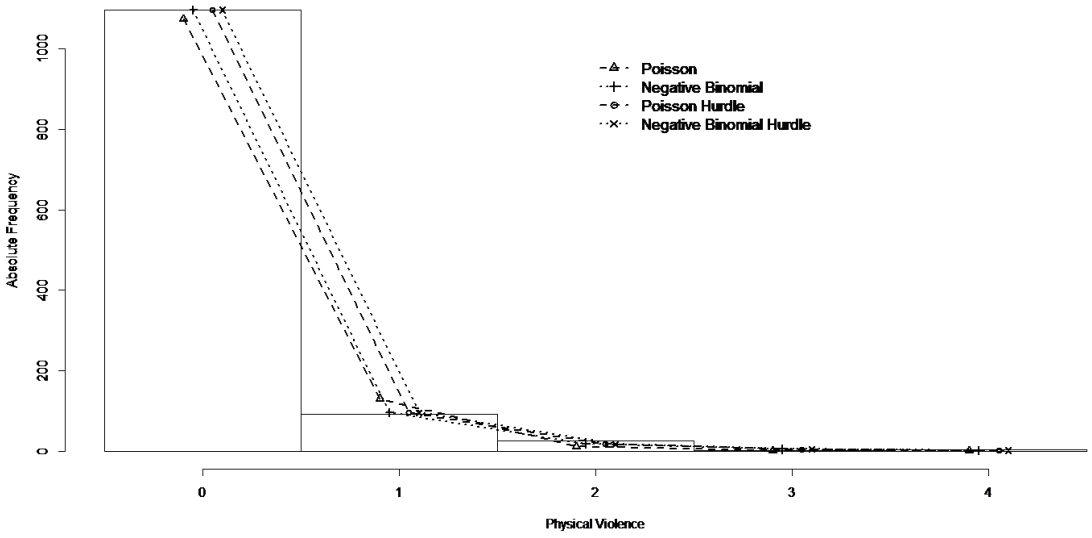

Figure 1. Histogram of Physical IPV Experiences with Predicted Frequencies from Different Types of Count Regressions

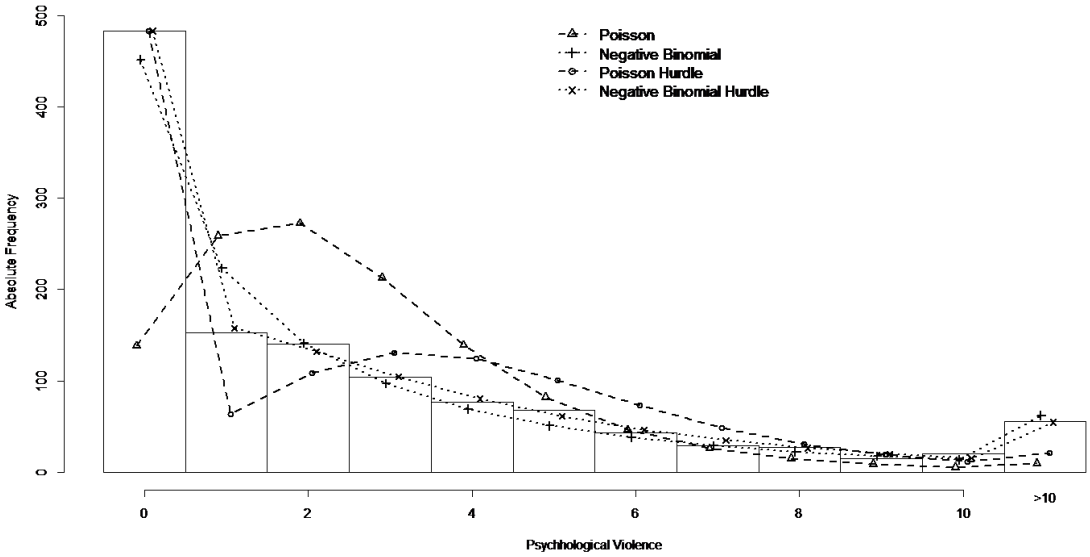

Figure 2. Histogram of Psychological IPV Experiences with Predicted Frequencies from Different Types of Count Regressions

Table 3 summarizes the effects from the NB model for physical IPV. No significant effects were found for the sociodemographics age, education level, relationship status, frequency of social contact, religion and income. In contrast, less social support and perceiving the family income as insufficient were significantly related to higher levels of physical IPV victimization. As hypothesized (H1a), no significant effect was found for gender: Controlling for the aforementioned sociodemographics, women and men reported on average the same frequency of lifetime physical IPV victimization.

The Hurdle NB model for psychological IPV revealed no significant effect for frequency of social contact, religion, and income either in the zero-hurdle part, or in the counts part (Table 3). In the zero-hurdle part, a significant effect was found for gender, age, education level, social support, and perception of income. This implies that the chance of being psychologically victimized decreased by 24% when the respondent was female (relative to male respondents), decreased by 2% for every unit increase in age, increased by 39% if they had a high level of education (relative to a lower education

level), decreased by 38% for every unit increase in social support, and decreased by 13% when they perceived their income as more comfortable. In the counts part, this regression showed that the variables education level, relationship status, social support and the subjective perception of income were significantly related to the frequency of experienced psychological IPV: Victims in a romantic relationship (relative to singles; *RR* = 0.63, a 37% decrease), those who had a higher education level (*RR* = 0.82, a 18% decrease), those who experienced more social support (*RR* = 0.76, a 24% decrease), and those who perceived their income as sufficient (*RR* = 0.90, a 10% decrease) reported less frequent acts of psychological IPV. To conclude, and partially in contrast to our hypothesis (H1b), men were more likely to report experiences with psychological IPV, but among the victims women and men reported psychological IPV equally frequent.

Table 3. Summary of Main Effects of the NB (physical IPV) and NBLH (psychological IPV) Models Testing Gender Differences and Socio-Demographic Control Variables

	Physical IPV	
Variables	*RR* (e^B)	95% CI
Gender[a]	1.09	[0.74, 1.60]
Age	0.10	[0.98, 1.01]
Education[b]	0.91	[0.60, 1.39]
Romantic relationship[c]	0.67	[0.42, 1.07]
Frequency contact friends	0.98	[0.84, 1.14]
Frequency contact family	0.94	[0.82, 1.10]
Social support	0.71**	[0.52, 0.98]
Religion	1.12	[0.95, 1.33]
Income	1.10	[0.66, 1.87]
Perception income	0.80***	[0.70, 0.92]

	Psychological IPV			
	Zero-inflation part		Counts part	
Variables	*OR* (e^B)	95% CI	*RR* (e^B)	95% CI
Gender[a]	0.74**	[0.58, 0.95]	1.03	[0.88, 1.21]
Age	0.98***	[0.97, 0.99]	0.10	[0.99, 1.00]
Education[b]	1.39**	[1.07, 1.81]	0.82**	[0.70, 0.96]
Romantic relationship[c]	0.73	[0.52, 1.03]	0.63***	[0.52, 0.75]
Frequency contact friends	1.08	[0.97, 1.20]	1.00	[0.94, 1.06]
Frequency contact family	0.92	[0.83, 1.01]	1.01	[0.95, 1.07]
Social support	0.62***	[0.49, 0.78]	0.76***	[0.66, 0.87]
Religion	0.96	[0.86, 1.07]	1.04	[0.97, 1.11]
Income	1.21	[0.87, 1.68]	1.01	[0.82, 1.23]
Perception income	0.87***	[0.78, 0.95]	0.90***	[0.85, 0.95]

Note. IPV = intimate partner violence; OR = odds ratios; RR = rate ratios; CI = confidence interval.
*** p* < .01. **** p* < .001.

[a] Reference category is male. [b]Education level was recoded into education level lower than high school degree (reference category)and a high school degree or above. [c]Reference category is not being in a romantic relationship.

IPV Victims' Mental, Relational, and Sexual Well-Being

Multivariate analysis of variance (MANOVA) was used to test whether IPV victimization (i.e., independent variables) affects victims' mental, relational, and sexual well-being. By including all continuous dependent variables (i.e., mental health, relationship dissatisfaction, attachment anxiety, attachment avoidance, sexual dissatisfaction, and sexual communication) simultaneously, MANOVA accounts for the relationship between outcome variables and can detect whether the predictors differ along a set of outcomes. Prior to MANOVA, the outcome variables were standardized. Separate analyses were performed for physical and psychological IPV. The full models included the control variables gender, age, and education level followed by respondents' scores on physical IPV or psychological IPV. Interaction terms with gender (i.e., Gender x Physical IPV, Gender x Psychological IPV) were entered to examine potential differences between female and male victims. To determine the nature of the interactions, Table 4 presents the effects of physical and psychological IPV on each of the six outcomes for men and women separately, and the difference in effects for both genders.

Lifetime physical IPV victimization is related to increased levels of relationship (H3a) dissatisfaction, sexual dissatisfaction (H6a), and avoidant attachment (H5a) in both women and men. A gender difference was found for relationship dissatisfaction, indicating a more adverse outcome for women than for men. Furthermore, only female victims report decreased levels of mental health (H2a), more difficulties with sexual communication (H7a), and increased anxious attachment (H4a).

Confirming our hypotheses, lifetime experiences with psychological intimate violence correspond with decreased levels of mental health (H2b) more difficulties with sexual communication (H7b), and with increased levels of relationship dissatisfaction (H3b), insecure attachment orientations (H4b and 5b) and sexual dissatisfaction (H6b) in the current intimate relationship in both men and women. Furthermore, gender differences were found in the link between lifetime psychological IPV victimization and

respondents' mental health, relationship dissatisfaction, anxious attachment, and avoidant attachment, indicating significantly more adverse mental and relational outcomes for women than for men (Table 4).

Finally, two separate multinomial logistic regressions were performed to examine the effects of physical and psychological IPV victimization (i.e., the independent variables) on respondents' sexual functioning (i.e., a three-level outcome variable). Results revealed no significant interaction terms with gender (Gender x Physical IPV, $\chi^2(2) = .89$, $p = .64$; Gender x Psychological IPV, $\chi^2(2) = 4.91$, $p = .09$). In both analyses, a significant effect was found for the sociodemographics gender and age: Women and older respondents were more likely to report sexual difficulties with distress compared to men and younger respondents. Furthermore, results revealed that physical IPV victimization was positively associated with sexual dysfunctions, $\chi^2(2) = 11.70$, $p = .003$: Whereas higher levels of physical violence did not increase the odds of sexual difficulties without distress – compared to no dysfunction – it increased the odds of sexual difficulties with distress by a factor of 1.96 [95% C.I. 1.32, 2.90]. Similarly, psychological IPV was positively associated with sexual dysfunctions, $\chi^2(2) = 26.36$, $p < .001$. An increase of one unit of lifetime psychological IPV did not increase the odds of sexual difficulties without distress – compared to no dysfunctions – but increased the odds of sexual difficulties with distress – compared to no dysfunctions – by a factor of 1.14 [95% C.I. 1.08, 1.19]. As predicted, higher levels of physical (H8a) and psychological (H8b) IPV victimization were related to increased odds of sexual dysfunction.

Table 4. Summary of Univariate Analyses to Predict Men and Women's Mental, Relational, and Sexual Well-being from Physical and Psychological IPV Victimization

	Men			Women			Difference		
Variables	*B*	*SE*	95% CI	*B*	*SE*	95% CI	*B*	*SE*	95% CI
				Physical IPV[a]					
Mental health	-.15	.13	[-.40, .11]	-.50***	.10	[-.69, -.32]	.36*	.16	[.04, .67]
Relationship dissatisfaction	.53***	.12	[.30, .77]	.86***	.09	[.69, 1.03]	-.33*	.15	[-.62, -.03]
Anxious attachment	.24	.13	[-.02, .50]	.29**	.10	[.10, .48]	-.05	.17	[-.37, .28]
Avoidant attachment	.35**	.13	[.09, .61]	.37***	.10	[.18, .56]	-.02	.17	[-.34, .30]
Sexual dissatisfaction	.32**	.13	[.07, .56]	.29***	.09	[.12, .47]	.03	.15	[-.28, .33]
Sexual communication	.16	.13	[-.10, .41]	.25**	.10	[.07, .44]	-.10	.16	[-.42, .22]
				Psychological IPV[b]					
Mental health	-.04**	.02	[-.07, -.01]	-.09***	.01	[-.12, -.07]	.05**	.02	[.01, .09]
Relationship dissatisfaction	.13***	.01	[.11, .16]	.21***	.01	[.19, .23]	-.08***	.02	[-.11, -.05]
Anxious attachment	.06***	.02	[.03, .09]	.10***	.01	[.08, .13]	-.04*	.02	[-.08, .00]
Avoidant attachment	.10***	.01	[.07, .13]	.14***	.01	[.11, .16]	-.04*	.02	[-.07, .00]
Sexual dissatisfaction	.08***	.01	[.05, .11]	.09***	.01	[.06, .11]	-.01	.02	[-.04, .03]
Sexual communication	.08***	.01	[.05, .10]	.08***	.01	[.05, .10]	.00	.02	[-.04, .04]

Note. B values are standardized regression coefficients.

[a]Multivariate tests using Wilks'Λ revealed significant effects for gender, $F(6, 910) = 9.83$, $p < .001$, education level, $F(6, 910) = 3.62$, $p < .001$, age , $F(6, 910) = 28.69$, $p < .001$, physical IPV, $F(6, 910) = 15.65$, $p < .001$, and gender x physical IPV, $F(6, 910) = .10$, $p < .05$. [b]Multivariate tests using Wilks'Λ revealed significant effects for gender, $F(6, 907) = 5.23$, $p < .001$, education level, $F(6, 907) = 3.77$, $p < .001$, age , $F(6, 907) = 29.08$, $p < .001$, psychological IPV, $F(6, 907) = 89.84$, $p < .001$, and gender x psychological IPV, $F(6, 907) = 6.54$, $p < .001$.

** p* < .05. *** p* < .01. **** p* < .001.

DISCUSSION

The current study examined the prevalence of lifetime physical and psychological IPV in a representative community sample of adult women and men and aimed to expand the IPV literature that addresses the harmful effects of lifetime IPV victimization. With regard to the latter objective, we gave special attention to the examination of IPV victims' relational and sexual well-being within their current intimate relationship because these forms of interpersonal well-being have – compared to IPV victims' mental well-being – not been extensively studied to date.

Our findings indicate that a substantial proportion of the population is confronted with some form of IPV during their lives. Our estimates show that 10.0% of the adults experienced at least one incident of physical IPV and 56.7% at least one incident of psychological IPV during their lives. Yet, the frequency with which one experienced acts of physical or psychological IPV tended to be low. Women and men reported equal levels of physical IPV victimization. More men than women reported psychological victimization but among the victims, there were no gender differences in the degree of psychological victimization. The findings that mainly mild forms of violence were reported and that no or only small gender differences were found in this community sample, plead for the conclusion that the present study – in line with Johnson's (1995) assumptions – predominantly measured common couple violence. Yet, this is only an assumption because, as is the case in most national surveys, no instruments measuring patterns of control were included to distinguish between the types of violence (Anderson, 2002). Furthermore, our findings suggest that people of all ages – regardless of the frequency of social contact with their family and friends, regardless of their romantic status, regardless of how important religion is to them, and regardless of their family income – occur the risk of experiencing physical IPV. However, higher levels of lifetime physical and psychological violence were reported by those people perceiving

their family income as insufficient, or those mentioning a lack of social support. Thus, while objective sociodemographic characteristics play no role or an inconsistent (i.e., education level) role in the understanding of IPV victimization, the way that people subjectively appraise these objective characteristics are related to experiencing IPV. This are important findings because the decision to leave or remain in an abusive relationship might depend on the perception of the income as being sufficient to become independent from the partner and because evidence has been found that elevated levels of social support reduce the risk of adverse mental outcomes among victims (Coker et al., 2002).

Main Findings on IPV Victims' Mental, Relational, and Sexual Well-Being

The current findings indicate that experiences with physical and psychological intimate violence have detrimental effects on victims' current mental, relational, as well as sexual well-being.

Associations between IPV victimization and a poor mental health are well documented in previous studies. Conformingly, we found higher levels of psychological IPV victimization to be related to a poorer mental health status (e.g., Follingstad, 2009). In addition, gender differences were found, which indicates that our study supports a gender perspective on psychological aggression as being more detrimental for women's mental well-being than it is for men's mental health. Furthermore, our findings are in line with the overall IPV literature demonstrating that physical IPV victimization is more harmful for women than it is for men.

Besides the effect on victims' mental health, the results of this study both replicate and extend prior work showing an association between IPV victimization and current relational well-being. As in previous studies (see Stith et al., 2008), IPV victimization was negatively related to relationship satisfaction. The latter authors argue that this association is in general stronger in clinical samples than in community samples.

However, the current study adds to the findings of Williams and Frieze (2005) that even in the context of low violence, a strong association is found between people's victimization rates and their current relationship satisfaction. Furthermore, like Stith and colleagues (2008) – who clearly described a deficit in knowledge on male victims' relationship satisfaction – this study found both women and men to report lower levels of relationship satisfaction when having experienced psychological or physical IPV. Yet, the effect of lifetime IPV on relationship satisfaction was more pronounced among women than men in our study.

Importantly, given that there is limited research addressing the association between the receipt of violence and attachment, our results support the available evidence for higher levels of anxious and avoidant attachment orientations among IPV victims in non-clinical samples (e.g., Henderson, Bartholomew, Trinke, & Kwong, 2005; Weston, 2008). The findings indicate that although both female and male victims reported more attachment anxiety and attachment avoidance, psychological IPV victimization was more detrimental for women's than for men's attachment orientations. With regard to physical victimization, both women and men reported more avoidant attachment orientations but only women were also more anxiously attached. How can the association between IPV victimization and attachment theoretically be understood? Attachment is considered as a cognitive and emotion regulation system that shapes relationship experiences via relationship schemes. Experiencing intimate violence may prompt negative emotions and relationship schemes which are, in turn, likely to activate the attachment system, and insecure attachment strategies. Traditionally, attachment orientations were approached as static personality characteristics that remain stable across relationships (Bowlby, 1969/1982, 1973). Nowadays, researchers take a more dynamic approach, stating that attachment is not simply a trait but might be influenced by relationship experiences (e.g., Fraley et al., 2011). As discussed by other researchers (e.g., Allison et al., 2008; Mikulincer & Shaver,

2007; Weston, 2008), our results suggest that insecure attachment orientations put people at risk to enter or remain in a violent relationship and/or that the involvement in a long-term violent relationship can trigger the development of insecure attachment orientations. As most studies, the current study is cross-sectional, and no definite conclusions can be drawn about these assumptions. Yet, a preliminary longitudinal study by Fraley et al. (2011) suggests that although attachment orientations are moderately stable over the lifespan, (negative) relationship experiences tend to influence and change people's attachment characteristics.

Last, our results clearly indicate that experienced violence negatively affects victims' sexual well-being. For instance, physical (only for women) and psychological IPV victimization were associated with a decrease in communication of sexual needs and wishes to the partner. The intimacy process model (Reis & Shaver, 1988) offers an interesting framework to understand the link between experiences with intimate violence and sexual communication. According to this model, the everyday interactions between partners either support or decrease the degree of intimacy in a relationship. The expression and disclosure of feelings and thoughts by one partner will depend on the responses of the other partner. Thus, the effects of an individual's behaviour on the relationship are determined by how these experiences are interpreted. Therefore, it could be that those people who experienced violence within a relationship – and are quite likely to have experiences with dysfunctional communication patterns (Cupach & Metts, 1991) – have more concerns about the current partners' possible emotional and behavioural reactions on the disclosure of personal and sensitive information about him or herself. Furthermore, empirical evidence has been found that a lack of sexual communication might contribute to less sexual satisfaction and more sexual distress (MacNeil & Byers, 2009).

Indeed, increased levels of physical and psychological IPV victimization were related to decreased levels of sexual satisfaction and to an increased probability of

reporting sexual difficulties *with* distress. In fact, that no association was found between IPV and sexual difficulties an sich but only with sexual difficulties with distress highlights the importance of the emotional aspect during sexual intimacy. These findings correspond with recent evolutions in sex research, which address the relational context as the main contributing factor for experiencing sexual dissatisfaction and sexual distress (Stephenson & Meston, 2010). Being confronted with violence may lead victims to protect themselves from being further abused or controlled, which implies that they will be more likely to focus on self-protection and control during sex rather than on emotional intimacy with their partner (Metz & Epstein, 2002).

Although women reported less sexual satisfaction and more sexual distress than men, our results revealed that physical and psychological IPV did not affect the sexual well-being of female and male participants differently. These results contrasted our expectations because research has indicated that sexual intimacy has a different meaning for women and men: Whereas men tend to be mainly motivated by the physical sexual pleasure, the sexual needs of women are more strongly associated with the relational context (Bancroft, 2003; Birnbaum et al., 2006; Schachner & Shaver, 2004; Traen & Skogerbo, 2009). Therefore, we expected the female victims in our study to report less sexual satisfaction and more sexual dysfunction than the male victims. Otherwise, it is possible that gender differences are found only for less severe relationship problems, and not when serious problems such as violence are involved. In support of this, a study by McCabe (1997) has found that men only developed signs of sexual dysfunction within an intimate relationship with significantly disturbed levels of intimacy whereas women already developed sexual dysfunction with moderated intimacy disturbances. Taken together, these results provide further evidence that IPV is associated with negative sexual outcomes, including impact upon people's sexual well-being within an intimate relationship.

Limitations

This study is not without limitations. First, given the cross-sectional nature of this study, no definitive conclusions can be drawn in terms of causes and effects. In this respect, the identified effects of IPV on victims' mental, relational and sexual well-being should be interpreted as *associations*. For instance, it is quite likely that experiences with intimate violence makes people less willing to communicate openly about their inner self. Nonetheless, it could also be that couples with poor communication resort to IPV to resolve difficulties. A longitudinal design would help to clarify the causal directions of the findings. This brings us to a second caution that should be voiced concerning causal inferences in the present study. That is, we do not know for sure whether respondents report on violence in the current or the former relationship, or possibly both relationships. Therefore, no clear statements can be made whether the adverse mental, relational and sexual outcomes are a long-term consequence from violence in the previous relationship or whether they are directly related to IPV in the current relationship. Either respondents reported on violence in the current relationship and then the associations that were found are most probably bidirectional. Or, in case respondents reported on violence that occurred in the previous relationship, it is logic to assume that the associations we found can be causally interpreted in view of the temporal order of our measurements (i.e., IPV in current/former relationship vs. relational and sexual well-being in the current relationship). Third, our sample was selected from the general population. This suggests that our sampling technique elucidated only a part of the problem. As perpetrators who dominate and routinely hurt their partner physically (i.e., intimate terrorism) will probably refuse their partner to participate in surveys on sexual health and relationships, community samples mainly represent common couple violence (Anderson, 2002; Johnson, 1995). For that reason, both community and clinical samples (e.g., shelter studies) are necessary to grasp IPV in its entirety and to explore how minor as well as severe forms of violence affect victims'

well-being. A final limitation concerns the weak internal consistency of the attachment subscales. For timesaving reasons, characteristic for large-scale representative studies as ours – a short version of the Experience in Close Relationships Scale was used. Although Wei et al. (2007) have argued that this short version of the ECR is a reliable and valid instrument to examine one's attachment orientation, the internal inconsistencies in the present study were lower than expected (especially for the attachment anxiety subscale). Despite this caveat, the use of this short version revealed results that are theoretically meaningful and in line with the overall literature. However, for future research, it would be better to consider using the full Experience in Close Relationships Scale.

Despite these weaknesses, our results broaden the empirical evidence that experiences with even low forms of violence are – besides their association with mental health – associated with victims' relational as well as sexual well-being within their intimate relationships. These findings emphasize the importance of future research and clinical practice on the interplay between adverse relationship experiences and relational as well as sexual interactions between partners.

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CHAPTER 4

PREVALENCE AND IMPACT OF INTIMATE PARTNER VIOLENCE IN AN ETHNIC MINORITY POPULATION[1]

ABSTRACT

The present study examined the prevalence of lifetime experiences of physical and psychological intimate partner violence (IPV) among members of the Turkish ethnic minority population in Flanders. Additionally, this study explored how lifetime IPV victimization impacts on ethnic minority victims' current mental, relational, and sexual well-being. Using a population-based representative sample, data from 392 adult Turkish women and men were investigated. Lifetime experiences of physical violence were reported by 14.3% of the Turkish respondents, while 66.0% reported at least one incidence of psychological abuse. Women were much more likely than men to report physical IPV victimization but no gender differences were found for psychological IPV. In regard to the impact of IPV, it was found that lifetime IPV experiences do not appear to affect victims' current mental health. However, higher levels of physical and/or psychological IPV victimization were related to increased levels of relationship dissatisfaction, anxious and avoidant attachment orientations, sexual dissatisfaction, sexual dysfunction, and to decreased levels of sexual communication. These adverse relational and sexual outcomes of IPV victimization were mainly present among women but were also, to a lesser degree, relevant for men.

[1] Based on Hellemans, S., Loeys, T., De Smet, O., & Buysse, A. (2013). *Prevalence and impact of intimate partner violence in an ethnic minority population.* Manuscript submitted for publication.

INTRODUCTION

The World Health Organization (WHO) defines intimate partner violence (IPV) as "behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours" (2010, p. 11). IPV crosses all ethnic/racial, sociodemographic, religious, gender, and sexual orientation boundaries (Bent-Goodley, 2005; Rizo & Macy, 2011). IPV research in specific modern western societies has led to the development of two opposing perspectives on violence between intimate partners (Archer, 2006; Johnson 1995; Johnson & Ferraro, 2000). One perspective is referred to as "intimate terrorism" and typically describes one-sided, severe forms of aggression. The other perspective is referred to as "common couple violence" and typically consists of minor forms of aggression. Whereas intimate terrorism is mainly viewed as a way of dominating and maintaining control over the partner, common couple violence is predominantly viewed as a harmful way of coping with conflict within a relationship. Although it is not yet well known to what extent these patterns also fit in the context of IPV across non-Western ethnic minority populations (Archer, 2006; Field & Caetano, 2004), it has been argued that community samples mainly portray common couple violence and that clinical samples are more likely to reveal intimate terrorism (Archer, 2000; Johnson, 1995; Johnson & Ferraro, 2000).

Despite the recent wave of campaigning against IPV, violence within intimate relationships remains a significant problem for a number of people. In order to gain a full picture of this social concern, population-based research should represent all populations in society, including minority populations. However, a lack of diversity in ethnicity is often noted as an important limitation across studies (e.g., Follingstad,

Rogers, & Duvall 2012). Influenced, presumably, at least partially by cultural factors, ethnic minority victims often condone their experiences of violence, live with intense shame related to the stigma of IPV, or fear harming their family and community if they were to disclose their experiences. Consequently, ethnic minority victims often remain invisible, both in society and in research (Malley-Morrison & Hines, 2007; Raj & Silverman, 2002; Rizo & Macy, 2011; Yick, 2007). Because IPV prevention and intervention efforts require a cultural background to be successful (Bent-Goodley, 2005; Sokoloff & Dupont, 2005), several scholars have recently highlighted the importance of a better understanding of IPV among ethnic minorities (e.g., Field & Caetano, 2004; Follingstad et al., 2012; Lacey, McPherson, Samuel, Powel Sears, & Head, 2013; Raj & Silverman, 2002; Tartakovsky & Mezhibovsky, 2012; Yick, 2007).

To date, empirical research on the prevalence of IPV among ethnic minorities, as well as on its impact on ethnic minority victims' well-being, is relatively sparse (Lacey et al., 2013). The small body of research that has been conducted in this area predominantly reports on ethnic minority populations in the U.S. (for an overview, see Taft, Bryant-Davis, Woodward, Tillman, & Torres, 2009). Furthermore, most cross-cultural studies on IPV victimization have only involved women, thereby excluding potential male victims of intimate violence (Archer, 2000, 2006). In order to fill these gaps in the research, the current study aimed to examine the prevalence of lifetime physical and psychological IPV victimization in a population-based representative sample of Turkish ethnic minority women and men in Flanders (i.e., the Dutch-speaking part of Belgium). Although immigration is often overlooked in Belgium, due to the small size of the country and the fact that its immigration history is not widely known, immigrants comprised almost 18% of the entire population in 2010. People of Turkish (5%) and Moroccan (10%) origin form the two largest non-Western ethnic minority groups (Levecque, Lodewycks, & Vranken, 2007; Timmerman, Vanderwaren, & Crul, 2003; www.migrationinformation.org). In addition, we aimed to examine how lifetime

experience of IPV victimization is related to an individual's current mental well-being as well as to one's well-being on a relationship level. As we will outline below, it has not yet been properly assessed how lifetime IPV victimization affects victims' relational and sexual well-being within their current intimate partner relationship.

The Prevalence of Intimate Partner Violence Among Ethnic Minority Women and Men

IPV among ethnic minorities. Studies on IPV victimization among ethnic minorities in the U.S. have consistently revealed that immigrants are a high risk group for intimate violence. That is, studies comparing IPV prevalence rates among ethnic minorities to the majority population consistently report higher IPV prevalence estimates in minority groups (e.g., Archer, 2006; Hien & Ruglass, 2009; Taft et al., 2009). Two main theoretical frameworks have been proposed to understand IPV among ethnic minorities, namely the structural inequality theory and the subculture of violence theory. The latter theory refers to the acceptance of violence by various cultural groups as a means of conflict resolution within intimate relationships (Field & Caetano, 2004). According to the structural inequality theory, intimate violence is a result of increased stress in intimate relationships due to institutionalized inequalities between groups (e.g., education, income, social support, racial discrimination; Field & Caetano, 2004; Gil, 1986). Strong empirical support has been found for the structural inequality theory as significant differences in IPV victimization between minority and majority groups decrease or disappear when sociodemographic factors such as education level, income, and social support are controlled for (e.g., Field & Caetano, 2004; Taft et al., 2009; Tartakovsky & Mezhibovsky, 2012). In contrast to the more stereotypical view of the subculture of violence theory, this theory stresses that societal structural factors, rather than cultural characteristics, of a specific group explain higher prevalence estimates among ethnic minority groups (Field & Caetano, 2004).

Ethnic minority women versus men. In Western community samples, evidence has been found for equal IPV victimization and perpetration rates among women and men (e.g., Archer, 2000). Yet, in non-Western community samples, men are more likely to perpetrate physical violence against women (Archer, 2006). The most popular theory to explain intimate violence against ethnic minority women fits with the intimate terrorism perspective detailed above (Johnson, 1995). That is, violence is the result of the maintenance of patriarchy and the dominant role of men over women in society. Indeed, historical and cultural traditions among ethnic minorities often indicate approval for a certain level of male-to-female violence as a way of maintaining control (Archer, 2006; Barthlomew & Cobb, 2011). For instance, studies among Asian and Middle-Eastern immigrant communities demonstrate that both women and men are tolerant to the use of physical aggression when a woman does not follow the prescribed rules (Erez, Adelman, & Gregory, 2009; Raj & Silverman, 2002). Additionally, immigrant women are more likely than immigrant men to alter their gender role ideologies to live according to the more egalitarian Western gender roles (Raj & Silverman, 2002). This implies that a sharp contrast might arise between the traditional values of men and the more modern values of women, which may in turn lead to a man attempting to increase his control over a woman, sometimes resorting to the use of violence (Archer, 2006; Colucci & Montesinos, 2013; Erez et al., 2009; Raj & Silverman, 2002). Laying the intimate terrorism perspective to one side, gender differences in IPV victimization among ethnic minorities can also be explained by means of the social role theory (Archer, 2006; Eagly & Wood, 1999b). According to this theory, gender differences in physical aggression against partners are related to gender empowerment in a specific culture. In a compelling study that used data from 16 different nations, Archer (2006) revealed that male-to-female intimate violence is inversely related to women's societal power. Across nations, rates of victimization of women decrease the more empowered they are.

In order to expand the limited research in the area of IPV among ethnic minorities, we examined to what extent a representative sample of Turkish women and men in Flanders — recruited by means of a population-based survey — report lifetime experiences of physical and psychological IPV victimization (RQ1). As the existing IPV literature reveals higher levels of intimate violence against immigrant women, we hypothesized that the Turkish women in our sample were more likely to report lifetime physical (H1a) as well as psychological (H1b) IPV victimization compared to Turkish men. To the best of our knowledge, no accurate data on IPV among this group was previously available for Flanders.

The Impact of Intimate Partner Violence on Victims' Well-Being

Western clinical and/or community samples have provided clear evidence that experience of violence within a romantic relationship has detrimental effects on a victims' mental, relational, and sexual well-being (e.g., Caldwell, Swan, & Woodbrown, 2012, Campbell, 2002; Coker et al., 2002; Krahé, Bieneck, & Möller, 2005). The relationship between IPV victimization and mental, relational, and sexual well-being has not been properly studied in ethnic minority populations, however (Taft et al., 2009). Therefore, this study examined whether, and to what extent, experiencing IPV affects the well-being of Turkish ethnic minority women and men.

Physical and psychological violence have consistently been linked to impaired mental health. Although there is no agreement on the specific constellation of the symptoms, depression, post-traumatic stress disorder, and low self-esteem are the most reported mental health difficulties among both female and male victims (e.g., Caldwell et al., 2012). Several scholars have provided evidence for adverse mental health outcomes among all women, regardless of their racial/ethnic and social background (Hicks & Li, 2003; Lacey et al., 2013; Yick, Shibusawa, & Agbayani-Siewert, 2003). In accordance to these studies, we hypothesized that our current investigation would find

that higher levels of physical (H2a) and psychological (H2b) IPV are associated with poorer mental well-being. Although we are not aware of studies focusing on male victims' mental health, we expected to find this association in both female and male respondents.

Both social learning theory and attachment theory are highly interesting concepts to explain the effects of negative relationship experiences, such as IPV, on a victim's cognitive and emotional responses in later intimate relationships. The social learning theory posits that relational outcomes are determined by couples' positive and negative interaction patterns (Bradbury & Karney, 2010). Over time, the accumulation of experience of conflict and violent interactions might influence the processing of social information and therefore people's judgments of intimate relationships, thus having a negative impact on their relationship satisfaction. Victims' relationship satisfaction has predominantly been examined in clinical samples, but some studies examining community samples have found that IPV victimization is related to higher levels of relationship dissatisfaction (e.g., Katz, Kuffel, & Coblentz, 2002; Williams & Frieze, 2005). According to attachment theory (Bowlby, 1969/1982, 1973), past relationship experiences translate into mental representations and influence how individuals think about and behave towards attachment figures. Attachment orientations are relatively stable throughout the lifespan. However, given the fact that individuals have a variety of interpersonal experiences with their significant others, it is likely that new relationship experiences influence an individual's attachment orientation (Collins & Read, 1994; Fraley, Vicary, Brumbaugh, & Roisman, 2011). As such, a history of violence within a romantic relationship might contribute to negative mental representations of the self and others, triggering the development of insecure attachment orientations. In line with the two-dimensional model of adult attachment proposed by Brennan, Clark, and Shaver (1998), a series of studies have found elevated levels of anxious and avoidant

attachment among IPV victims (e.g., Doumas, Pearson, Elgin, & McKinley, 2008; Henderson, Bartholomew, Trinke, & Kwong, 2005; Weston, 2008).

IPV has been considered in the clinical literature to contribute to a decline in sexual well-being (Coker, 2007). For example, significant associations have been found between physical IPV victimization and sexual risk-taking behaviours, inconsistent condom use, unwanted pregnancies and abortions, and sexual transmitted diseases (for a detailed overview see Coker, 2007). However, how experiences with intimate violence influence victims' sexual well-being and sexual communication within an intimate romantic relationship has not been systematically studied to date, especially with regard to satisfaction with the quality and frequency of sex and by the absence of sexual dysfunction (Bodenmann, Ledermann, & Bradbury, 2007). To the best of our knowledge, no studies have examined these associations for ethnic minorities in a community sample.

As there has been little research on relational and sexual responses to violence by an intimate partner in general, and among ethnic minorities in particular, it is difficult to make predictions about the potential impact of lifetime IPV victimization on ethnic minority victims' relational and sexual well-being in their relationship with their current partner. As considerable evidence has been gathered for cultural-related differences in thoughts, beliefs and emotions (Markus & Kitayama, 1991) and intimate interactions with romantic partners (Barthlomew & Cobb, 2011; Marshall, 2008), it is likely that cultural differences will influence victims' responses to intimate violence. Despite the lack of supporting research, we hypothesized, based on logical reasoning, that higher levels of lifetime physical and psychological violence would be positively related to relationship dissatisfaction (H3a & H3b), the level of anxious (H4a & H4b) and avoidant (H5a & H5b) attachment orientation, sexual dissatisfaction (H6a & H6b), and sexual dysfunction (H7a & H7b). We also predicted that these experiences would be negatively

related to the level of sexual communication (H8a & H8b) in the current intimate relationship. Differences between women and men were explored.

METHOD

Participants and Procedure

This study draws on data from the survey "Sexual Health of Ethnic Minorities in Flanders" (abbreviated to SEM). This survey includes extensive information on sexuality, sexual health, relationships, and biomedical, psychological, demographic and socio-cultural correlates. Data were gathered in a population-based probability sample drawn from the two largest, non-Western, ethnic minorities in Flanders: people of Turkish or Moroccan descent. The sampling method in the SEM study followed a multi-stage procedure. The first stage included the selection of Primary Sampling Units (*PSU*s), i.e., the Flemish municipalities. By ordering and systematic sampling, we ensured that the chance of a municipality being selected was proportional to the number of inhabitants meeting the criteria for eligibility (i.e., between 14 and 59 years of age, of Belgian nationality, and with at least one parent born with either Turkish or Moroccan nationality). In a second stage, we selected respondents randomly from the Belgian National Register. Since a very low response rate (26%) was obtained in the subsample of Moroccan descent, we only proceeded with the subsample of Turkish descent (N = 432, response rate: 57% of eligible respondents) in further analyses. After data collection, the data were weighted by gender and age in order to make them representative of the total population of Flemish residents of Turkish extraction, aged 14-59.

Data were gathered via face-to-face interviews. A mixed CAPI (Computer-Assisted Personal Interviewing) and CASI (Computer-Assisted Self-Interviewing) set-up was used

to account for the (most) sensitive items in the questionnaire. In particular, a wide range of sexual health characteristics were gathered in a CASI set-up, so that respondents never had to share private information about their sexual health with an interviewer. To make sure that respondents would feel at ease with answering these sensitive questions, women were predominantly interviewed by bilingual Dutch-Turkish/Moroccan female interviewers and men by Dutch-Turkish/Moroccan male interviewers. Interviewers were given training on the topic of the questionnaire as well as on the contact and interview procedure. Respondents could fill out the questionnaire in Dutch, Turkish or in Arabic.

In the current study, we specifically report on adult respondents of Turkish origin (≥ 18 years; *N* = 392). Respondents' country of birth was either Turkey (51.0%) or Belgium (49.0%). Almost all respondents' mothers (94.9%) and fathers (95.7%) were born in Turkey. Respondents' main reasons for moving to Belgium included accompanying their parents (37.4%), in order to marry their current partner (34.3%), to reunite their family (11.5%) or other reasons (16.8%; e.g., work, study, previous marriage, political refugee). The mean age of the women (*n* = 197) was 34.32 years (*SD* = 10.74, Range: 18-60) and the mean age of the men (*n* = 195) was 34.71 years (*SD* = 11.02, Range: 18-60). The majority of women (73.5%) and men (78.5%) were in a romantic relationship at the time of the survey. Respondents' current intimate partner's country of birth was Turkey (61.6%), Belgium (34.2%), or another country (4.2%). About thirteen percent of the respondents were still studying, 54.8% held no educational degree or a secondary school degree, 8.5% had earned a secondary school degree, 8.5% held a bachelor degree, and 4.2% had earned a higher-level university degree. Islamic religion was reported by 94.0% of the respondents and this was viewed as very important by most respondents (*M* = 4.36, *SD* = .97 on a 5-point Likert scale ranging from 1 = *very unimportant* to 5 = *very important*).

Measures

Sociodemographic characteristics. In addition to the respondent characteristics described above, we examined several sociodemographic risk factors associated with IPV victimization. Although these factors have been shown to be risk markers for IPV victimization for a general population (see Stith, Penn, Ward, & Tritt, 2004), they have a particular link with IPV victimization among ethnic minorities (see Field & Caetano, 2004; Malley-Morrison & Hines, 2007): The frequency of social contact with family (0 = *not at all in the past six months* to 7 = *daily or almost daily*) and friends (0 = *not at all in the past six months* to 7 = *daily or almost daily*), whether their family income is above 2000 euros a month (1 = *no* and 2 = *yes*), and how comfortable they found this income to live with (1 = *very uncomfortable* to 7 = *very comfortable*). In addition, social support was measured by five questions (e.g., "There are several people I can go to for a chat when I feel lonely."), each of which was rated on a 5-point Likert scale (1 = *totally disagree* to 5 = *totally agree*). A score for social support was computed by summing the scores for each item (α = .82). Finally, we adapted concepts described by Williams, Yu, Jackson, and Anderson (1997) and assessed perceived racial discrimination (10 items; e.g., "Have you been treated with less respect than others?") on a 7-point Likert scale (1 = *never* to 7 = *daily*). A higher sum score reflects more perceived racial discrimination. This scale proved to be internally consistent in the current study (α = .92).

Intimate partner violence. To identify lifetime IPV victimization, respondents were asked about experiences of physical or psychological violence at the hands of a current or former partner. Physical IPV was assessed with one question measuring different acts of physical violence (adapted from the Conflict Tactics Scale, CTS; Straus, 1979): "If you think about your current or former partner, has he/she ever hit you with the flat of their hand, hit you with their fist, kicked you, or physically hurt you in another way?" This item was rated on a 5-point Likert scale (0 = *never* to 4 = *very often*).

Seven items – adopted and modified from the WHO Multi-country Study on Women's Health and Domestic Violence against Women (Garcia-Moreno, Jansen, Ellsberg, Heise & Watts, 2005) – were used to assess psychological IPV victimization. Specifically, respondents were asked "If you think about your current or former partner, has he/she ever..." followed by: (a) "tried to limit the contact you have with your friends or family members?", (b) "insisted on knowing your whereabouts and who you are with at every moment of the day?", (c) "ignored you or treated you indifferently?", (d) "criticized you or ridiculed you for what you do or say?", (e) "belittled or humiliated you in front of other people?", (f) "intentionally done something to scare or intimidate you?", or (g) "threatened to hurt you or someone you love?". Each item was rated on a 5-point Likert scale (0 = *never* to 4 = *very often*). A Principal Component Analysis based on the eigenvalues revealed a single factor solution with approximately equal weights for all items. A scale for psychological violence was computed by summing the scores for each item, with a higher score indicating more severe psychological victimization (Range: 0-28). This seven-item measure proved to be internally consistent (α = .88).

Mental health. A five-item short version of the 18-item Mental Health Inventory (MHI; Veit & Ware, 1983) was used to assess respondents' current mental health. Each item (e.g., "During the past four weeks, how much of the time did you feel like a happy person?") was scored on a 6-point Likert scale (0 = *never* to 5 = *all the time*). A score for mental well-being was computed by summing the scores for all items, with a higher score reflecting a better level of mental well-being (Range: 0 – 25). The alpha reliability for this five-item measure was .79 in the present study.

Relationship satisfaction and sexual satisfaction. Respondents' relationship satisfaction and sexual satisfaction within their current relationship were assessed by means of the Maudsley Marital Questionnaire (MMQ; Arrindell, Boelens, & Lambert, 1983; Crowe, 1978). Whereas the original scale consists out of three subscales, the present study only used the relationship satisfaction (10 items; e.g., "Regardless of sex,

how satisfied are you about the life with your partner?") and the sexual satisfaction (4 items[2]; e.g., How much do you enjoy having sex with your partner?") subscales. Each item was rated on a 9-point Likert scale (0 = *very satisfied* to 8 = *very unsatisfied*). A total score for relationship satisfaction as well as for sexual satisfaction were computed by summing the scores of all items in each scale. Higher scores correspond with greater relationship *dis*satisfaction (Range: 0 – 80) and greater sexual *dis*satisfaction (Range: 0-32). The alpha reliabilities were .91 (relationship satisfaction) and .74 (sexual satisfaction).

Adult attachment style. To assess individual differences in respondents' attachment style towards their current partner, the 12 item short version of the Experiences in Close Relationships Scale (ECR-S; Wei, Russell, Mallinckrodt, & Vogel, 2007; Dutch version by Conradi, Gerlsma, van Duijn, & de Jonge, 2006) was used. The ECR-S is comprised of two scales, attachment anxiety (6 items; e.g., "I worry that my partner won't care about me as much as I care about him/her.") and attachment avoidance (6 items; e.g., "I am nervous when my partner gets too close to me."). Each item was scored on a 5-point Likert scale (1 = *totally disagree* to 5 = *totally agree*). A higher score on each scale reflected greater attachment anxiety and greater attachment avoidance. The cronbach alpha was .47 for the anxiety scale and .66 for the avoidant scale. Dropping out one item of the anxiety scale increased the Cronbach alpha to .60.

Sexual function and sexual distress. Impaired sexual function and sexual distress associated with impaired sexual function was assessed using the Sexual Functioning Scale (SFS; Enzlin et al., 2012). The SFS covers a range of sexual problems such as increased or decreased spontaneous/responsive sexual desire, arousal dysfunction, orgasmic dysfunction, dyspareunia, vaginismus, retrograde ejaculation, and lack of a forceful propulsive ejaculation. All sexual difficulties (e.g., "In the past six months, did

[2] The original sexual satisfaction scale consists out of 5 items but one item was dropped out in the computer program and could not be retrieved.

you have the feeling that you had a decreased interest in sex, in sexual activities or decreased sexual fantasies or erotic thoughts?") were rated on a 4-point scale (1 = *none* to 4 = *severe or extreme*). To determine the clinical significance of these sexual difficulties, respondents who had scores of ≥ 2 on any of these items were asked to evaluate how any distress associated with each sexual difficulty: They were asked to what extent they experienced this sexual difficulty as a source of distress for themselves, for their partner, and for their relationship. Each type of distress was scored 1 (= *no or mild distress*), 2 (= *moderate distress*) or 3 (= *severe or extreme distress*). Distress was considered to be present if they had a sum score of ≥ 5 (i.e., moderate levels of distress in at least two of three domains, namely personal distress, partner distress or relational distress). For this study, a sexual dysfunction scale was computed (0 = *no dysfunction*, 1= *one or more sexual difficulties without distress,* 2 = *one or more sexual difficulties with distress*)

Sexual communication. Sexual communication within the current relationship was assessed by means of the four-item short version of the 13-item Dyadic Sexual Communication Questionnaire (DSC; Catania, 1986). Each item (e.g., "How often in the past six months did you find it difficult to discuss sexual matters with your partner?") was rated on a 5-point Likert scale (1 = *never* to 5 = *almost always or always*) and a total score for sexual communication was computed by summing the scores for all items (Range: 4 – 20). A higher score corresponds with experiencing a greater level of difficulty when discussing sexual topics with the partner. The Cronbach alpha of this four-item measure was .51 in the present study.

RESULTS

Prevalence of Intimate Partner Violence Among Turkish Ethnic Minorities

Before standardizing the continuous outcome variables, descriptive statistics and correlations were examined (see Table 1). Respondents reported on average a good level of mental health and relatively high levels of relationship satisfaction and sexual satisfaction. Moderate levels of attachment anxiety, attachment avoidance, and sexual communication were found. Overall, lifetime experiences of physical IPV were reported by 14.3% of the Turkish respondents. Sixty six percent reported having experienced at least one act of psychological violence (Table 2). The most commonly reported act of psychological IPV among this Turkish sample was that a partner "insisted upon knowing [your] whereabouts every moment of the day". In contrast, that a partner had "threatened to hurt either [you] or someone [you] love" was the least frequently reported act. Further, according to the frequencies, low to moderate counts of physical and psychological IPV victimization were uncovered. In line with the IPV literature, a strong correlation was found between the two forms of aggression ($r = .54$, $p < .001$).

Table 1. Descriptive Statistics and Pearson Correlations of the Main Variables

Variable	*N*	*M (SD)*	*Min*	*Max*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
Physical IPV	378	.24 (.69)	0.00	4.00	.54**	-.06	.33**	.07	.25**	.28**	.11
Psychological IPV	313	2.77 (4.31)	0.00	28.00	-	-.19**	.47**	.22**	.37**	.26**	.14*
Mental health	380	17.69 (4.18)	0.00	25.00		-	-.33**	-.22**	-.13*	-.22**	-.19**
Relationship dissatisfaction	266	14.94 (12.71)	2.00	73.00			-	.27**	.51**	.51**	.28**
Anxious attachment	237	2.50 (.74)	1.00	5.00				-	.36**	.27**	.09
Avoidant attachment	237	2.19 (.74)	1.00	4.50					-	.41**	.41**
Sexual dissatisfaction	266	7.30 (5.80)	2.00	32.00						-	.35**
Sexual communication	234	9.92 (3.27)	4.00	20.00							-
Sexual dysfunctions	295	No = 61.6 %, without distress = 25.2%, with distress = 13.3 %									

Note. IPV = intimate partner violence.

** $p < .01$.

Table 2. Descriptive Statistics and Frequencies of Lifetime IPV Victimization

Physical IPV	*M (SD)*	*%*
Hit you with the flat of their hand, with their fist, kicked you or physically hurt you in another way	.24 (.69)	14.3%
Psychological IPV	2.77 (4.31)	66.0%
Tried to restrict your contact with family and friends	.39 (.78)	23.8%
Insisted upon knowing your whereabouts every moment of the day	.66 (.10)	37.7%
Ignored you and treated you indifferently	.50 (.89)	29.6%
Criticized you or ridiculed you for what you do or say	.43 (.86)	26.1%
Belittled or humiliated you in front of other people	.29 (.72)	17.7%
Intentionally done something to scare or intimidate you	.17 (.64)	8.7%
Threatened to hurt either you or someone you love	.13 (.57)	6.3%

Note. IPV = intimate partner violence.

Sociodemographic characteristics of IPV victimization. Scores on physical and psychological IPV victimization were not normally distributed in this sample (see Figures 1 and 2). In order to handle the skewed distribution of experiences with physical and psychological IPV, researchers typically classify respondents in two or three categories (e.g., Romans, Forte, Cohen, Du Mont, & Hyman, 2007) although this results in the loss of meaningful variance of the continuous dependent variable. Moreover, using categorical instead of continuous variables may result in different findings (e.g., Doumas et al., 2008). To appropriately analyze (right-) skewed count outcomes, several count models have been developed including Poisson regression, negative binomial regression (NB), zero-inflated Poisson regression and zero-inflated NB regression (see Atkins & Gallop, 2007; Karazsia & van Dulmen, 2010). As an alternative to the latter two zero-inflated models, researchers have recently developed the Poisson logit hurdle model and the hurdle NB model (NBLH), which offer a more transparent split of the distribution into zero and non-zero counts (for a detailed explanation, see Loeys, Moerkerke, De

Smet, & Buysse, 2012). Graphs and statistical tests (outlined in Atkins & Gallop, 2007; Loeys et al., 2012) revealed that the NB model best fitted for the dependent variable physical victimization, and the NBLH model best fitted for psychological victimization. In the NBLH model, the *probability* of all non-zero counts relative to all zero-counts (i.e., the zero-hurdle part) is modelled using a binary logistic regression. The *frequency* of all non-zero counts (i.e., the counts part) is modelled using a truncated NB regression. In the current study, the zero-hurdle part examined the effect of gender and the aforementioned sociodemographics on the *likelihood* of experiencing lifetime IPV, while the counts part examined the effect of gender and the other sociodemographics on the *frequency* of lifetime IPV experiences among victims. In each part, the regression coefficients were exponentiated (e^B) and, respectively, called odds ratios (*ORs*) and rate ratios (*RRs*). Converted to percentages (100 x (e^B-1), *ORs* showed the percentage decrease (*OR* < 1) or increase (*OR* > 1) in the odds of experiencing IPV victimization, whereas RRs showed the percentage decrease (*RR* < 1) or increase (*RR* > 1) in the expected IPV frequencies for each unit increase in the independent variable, controlling for the other predictors in the model.

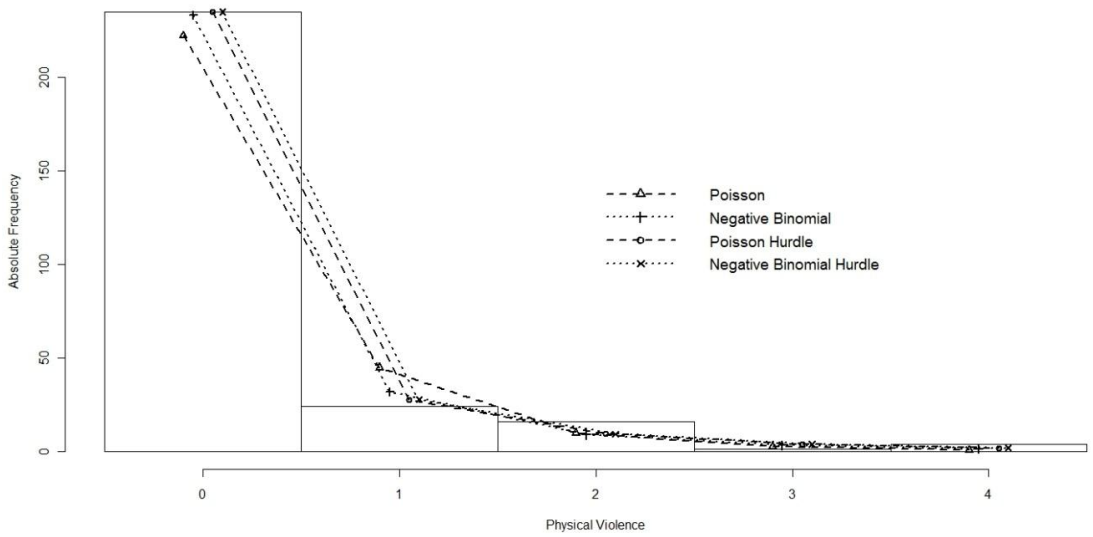

Figure 1. Histogram of Physical IPV Experiences with Predicted Frequencies from Different Types of Count Regressions

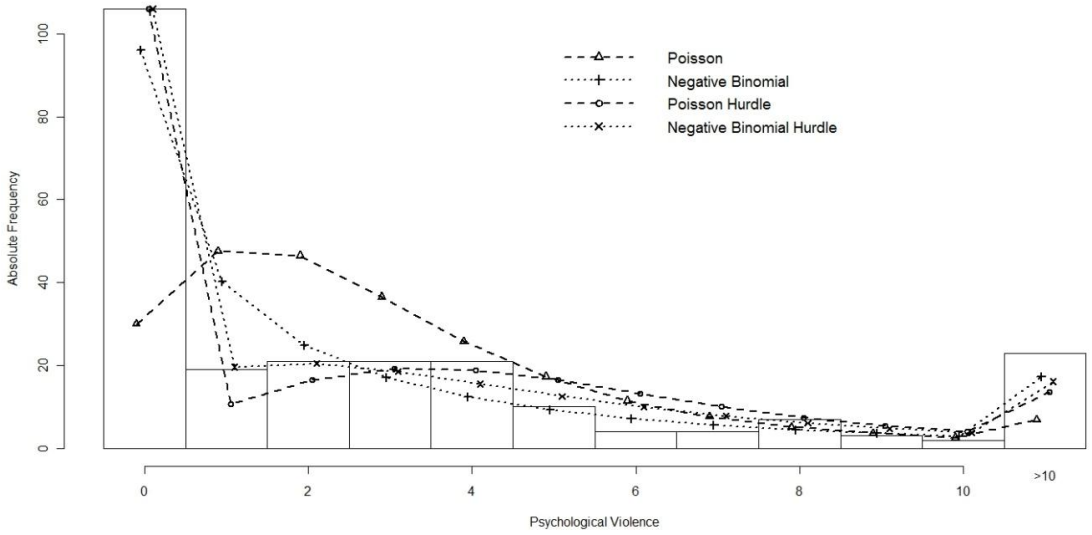

Figure 2. Histogram of Psychological IPV Experiences with Predicted Frequencies from Different Types of Count Regressions

Table 3 summarizes the results of the NB model for physical IPV victimization. As hypothesized (H1a), a significant effect was found for gender: Being a Turkish ethnic minority woman strongly increased the likelihood of physical aggression (603% increase relative to men). Furthermore, a higher level of education (relative to a low education level; *RR* = 0.32, a 68% decrease), and currently being in a romantic relationship (relative to being single; *RR* = 0.43, a 57% decrease) were significantly related to lower levels of lifetime physical IPV victimization. No significant effect was found for age, the frequency of social contact with family or friends, social support, racial discrimination, religion, income, or the perception of income.

In contrast to our expectations (H1b), no significant effect was found for gender in either the zero-hurdle part or in the counts part of the NBLH model for psychological IPV. This implies that Turkish ethnic minority women were as likely as Turkish ethnic minority men to report lifetime experiences with psychological violence and that female and male victims reported no differences in frequency of experienced psychological aggression. Neither part revealed a significant effect for education level, frequency of social contact with family or friends, racial discrimination, income, and the perception of income. The zero-hurdle part only revealed a significant effect for age and religion: The odds of experiencing lifetime psychological violence decreased by 4% for every unit increase in age and increased by 66% for every unit increase in the importance an individual attached to religion. In the counts part, results revealed that victims who were in a romantic relationship (relative to singles; *RR* = 0.45; a 55% decrease) and those who mentioned higher levels of social support (*RR* = 0.69; a 31% decrease) reported less frequent acts of psychological violence.

Table 3. Summary of Main Effects of the NB (physical IPV) and NBLH (psychological IPV) Models Testing Gender Differences and Socio-Demographic Control Variables

	Physical IPV	
Variables	*RR* (e^B)	95% CI
Gender[a]	6.03***	[2.40, 18.55]
Age	1.01	[0.98, 1.05]
Education[b]	0.32**	[0.09, 0.93]
Romantic relationship[c]	0.43**	[0.21, 0.84]
Frequency contact friends	1.06	[0.78, 1.46]
Frequency contact family	0.86	[0.66, 1.11]
Social support	1.03	[0.62, 1.71]
Racial discrimination	1.19	[0.66, 2.06]
Religion	1.04	[0.70, 1.60]
Income	1.90	[0.94, 3.85]
Perception income	0.93	[0.74, 1.15]

	Psychological IPV			
	Zero-inflation part		Counts part	
Variables	*OR* (e^B)	95% CI	*RR* (e^B)	95% CI
Gender[a]	0.74	[0.40, 1.37]	1.23	[0.90, 1.70]
Age	0.96***	[0.93, 0.99]	1.01	[0.99, 1.02]
Education[b]	0.52	[0.24, 1.11]	1.27	[0.87, 1.84]
Romantic relationship[c]	0.83	[0.42, 1.63]	0.45***	[0.33, 0.60]
Frequency contact friends	1.05	[0.82, 1.35]	1.03	[0.91, 1.16]
Frequency contact family	0.98	[0.78, 1.23]	1.04	[0.94, 1.16]
Social support	0.68	[0.41, 1.10]	0.69***	[0.54, 0.87]
Racial discrimination	1.39	[0.88, 2.20]	1.13	[0.91, 1.40]
Religion	1.66***	[1.19, 2.32]	1.02	[0.84, 1.24]
Income	1.49	[0.75, 2.94]	1.09	[0.78, 1.53]
Perception income	1.06	[0.88, 1.28]	0.94	[0.86, 1.04]

Note. IPV = intimate partner violence. OR = odds ratios. RR = rate ratio. CI = confidence interval.
** $p < .01$. *** $p < .001$.

[a]Reference category is male. [b]Education level was recoded into education level lower than high school degree (reference category) and a high school degree or above. [c]Reference category is not being in a romantic relationship.

IPV Victims' Mental, Relational, and Sexual Well-Being

Multivariate analysis of variance (i.e., MANOVA) was used to determine how lifetime IPV victimization affects victims' current mental, relational (i.e., relationship satisfaction, attachment anxiety and avoidance) and sexual (i.e., sexual satisfaction and sexual communication) well-being to account for the interrelationships between all continuous dependent variables. Separate analyses were carried out for physical and psychological IPV, controlling for potential effects of gender, age, and education level. To explore whether intimate violence affects the mental, relational, or sexual well-being of Turkish women and men differently, interaction terms between gender and violence were included in both models. Table 4 demonstrates how IPV victimization is related to each of the six outcomes for women and men separately, and shows the differences in effects for both genders.

In contrast to our expectations, lifetime physical IPV victimization was unrelated to adverse mental health outcomes (H2a) in both Turkish men and women. In contrast to this, experiences with physical aggression were related to adverse relational outcomes but gender differences were found: Women reported increased levels of relationship dissatisfaction (H3a) and avoidant attachment orientations (H5a) whereas men reported elevated levels of attachment anxiety (H4a). Furthermore, only women reported higher levels of sexual dissatisfaction (H6a) and no association was found with sexual communication (H7a).

Similar to lifetime physical IPV, lifetime experiences of psychological violence were not associated with victims' mental health scores (H2b). Whereas both victimized women and men reported increased levels of relationship dissatisfaction (H3b), only women reported more attachment avoidance (H5b), sexual dissatisfaction (H6b), and more difficulties with sexual communication (H7b). No effect was found for attachment anxiety (H4b).

Table 4. Summary of Univariate Analyses to Predict Men and Women's' Mental, Relational, and Sexual Well-being from Physical and Psychological IPV Victimization

	Men			Women			Difference		
Variables	*B*	*SE*	95% CI	*B*	*SE*	95% CI	*B*	*SE*	95% CI
				Physical IPV[a]					
Mental health	.32	.31	[-.29, .94]	-.14	.15	[-.43, .16]	.46	.34	[-.22, 1.14]
Relationship dissatisfaction	-.22	.30	[-.81, .37]	.44**	.14	[.16, .73]	-.66*	.33	[-1.31, .01]
Anxious attachment	1.56***	.31	[.94, 2.18]	-.08	.15	[-.38, .22]	1.64***	.35	[.96, 2.32]
Avoidant attachment	.63	.32	[-.01, 1.26]	.55***	.15	[.25, .85]	.08	.35	[-.62, .78]
Sexual dissatisfaction	.30	.30	[-.29, .88]	.31*	.14	[.03, .59]	-.01	.33	[-.66, .64]
Sexual communication	.45	.34	[-.22, 1.11]	.18	.16	[-.13, .50]	.26	.37	[-.47, .99]
				Psychological IPV[b]					
Mental health	.03	.04	[-.06, .11]	-.04	.03	[-.10, .01]	.07	.05	[-.03, .17]
Relationship dissatisfaction	.10*	.04	[.02, .17]	.14***	.03	[.09, .19]	-.05	.05	[-.14, .04]
Anxious attachment	.06	.04	[-.03, .14]	.04	.03	[-.02, .09]	.02	.05	[-.08, .12]
Avoidant attachment	.08	.04	[.00, .16]	.15***	.03	[.09, .20]	-.07	.05	[-.17, .03]
Sexual dissatisfaction	.05	.04	[-.03, .13]	.08**	.03	[.03, .14]	-.03	.05	[-.12, .07]
Sexual communication	.05	.04	[-.03, .14]	.08**	.03	[.02, .14]	-.03	.05	[-.13, .08]

Note. B values are standardized regression coefficients.

[a]Multivariate tests using Wilks'Λ revealed no significant effects for gender, $F(6, 177) = 1.37$, $p = .23$, education level, $F(6, 177) = 1.03$, $p = .41$, age , $F(6, 177) = 1.56$, $p = .16$. Significant effects were found for physical IPV, $F(6, 177) = 4.59$, $p < .001$, and gender x physical IPV, $F(6, 177) = .6.77$, $p < .001$. [b]Multivariate tests using Wilks'Λ only revealed significant effects for psychological IPV, $F(6, 156) = 5.87$, $p < .001$. No significant effects were found for gender, $F(6, 156) = .69$, $p = .66$, education level, $F(6, 156) = 1.20$, $p = .31$, age , $F(6, 156) = 1.37$, $p = .23$, and gender x psychological IPV, $F(6, 156) = 1.37$, $p = .53$.

** p < .05. ** p < .01. *** p < .001.*

The relationship between lifetime experiences with physical or psychological IPV and respondents' current sexual functioning (i.e., a three-leveled outcome variable) was assessed through two separate multinomial logistic regression analyses. No significant interaction terms were found, indicating that physical and psychological IPV victimization did not affect Turkish women and men's sexual functioning differently. Results showed that physical violence was not associated with sexual difficulties without distress (compared to no dysfunction). In contrast, compared to no dysfunction, higher levels of physical IPV increased the odds of sexual difficulties *with* distress by a factor of 4.58 [95% C.I. 2.39, 8.76]. More pronounced results were found for psychological IPV victimization. Compared to no dysfunction, higher levels of psychological violence increased the odds of sexual difficulties without distress by a factor of 1.16 [95% C.I. 1.04, 1.29] and the odds of sexual difficulties *with* distress by a factor of 1.35 [95% C.I. 1.20, 1.51].

DISCUSSION

The present study aimed at a better understanding of IPV among ethnic minorities, a topic that has only rarely been investigated outside the U.S. More specifically, this study examined the occurrence of lifetime physical and psychological IPV in a population-based representative sample of Turkish immigrants in Flanders. Additionally, this study aimed to assess how experiences with intimate violence impact on victims' mental well-being as well as their relational and sexual well-being within their current intimate relationship.

Prevalence of IPV Among Ethnic Minorities

Lifetime prevalence estimates for IPV indicate that one in seven respondents have experienced physical violence and that two thirds of the respondents have experienced

psychological violence at some point at the hands of an intimate partner. The frequency of these acts of aggression tended to be low, however. In line with theoretical assumptions and previous studies (Archer, 2006; Field & Caetano, 2004), the Turkish women in our sample were much more likely to have been confronted with physical violence than men. In contrast, women and men were equally likely to have experienced psychological violence. This pattern of results raises the question whether IPV in this Turkish ethnic minority community sample reflects the same dynamics as in a Western community sample. As mentioned before, it is not clear whether the distinction between common couple violence and intimate terrorism is relevant for non-Western communities. In line with the common couple violence perspective, most of the incidences of physical and psychological aggression reported were minor and no gender difference was found for psychological IPV. However, the fact that there is clearly more male-on-female physical aggression suggests that physical violence might be a manifestation of a patriarchal culture, where men try to dominate and control their female partners (Johnson, 1995). Alternatively, drawing from the social role theory, it can be hypothesized that the Turkish women in our sample were less empowered, leaving them more vulnerable to experiencing physical IPV (Archer, 2006; Eagly & Wood, 1999b). Indeed, results from a nationally representative survey on IPV in Turkey revealed that although women and men have equal rights in law, women are less empowered than men in day-to-day life (Yüksel-Kaptanoglu, Türkyilmaz, & Heise, 2012). This latter statement requires careful interpretation, however, as it is not easy to generalize results from a community sample in Turkey to the current context in which Turkish respondents form a minority population. In fact, it might be that this minority status causes societal stress (i.e., minority stress) in Turkish men, which in turn generates frustration and anger against society and oneself. As these feelings of anger and frustration cannot be acted out in public because of fear of stigmatization, aggression could be acted out against intimate partners (Colluci & Montesinos, 2013;

Taft et al., 2009). These dynamics are only hypothetical and deserve to be investigated more in depth in future research.

Some sociodemographic factors have been cited in the literature as increasing the likelihood of IPV victimization (see Field & Caetano, 2004; Malley-Morrison & Hines, 2007; Stith et al., 2004). In contrast to what has been reported in the past, the frequency of social contact, degree of experienced racial discrimination, income level, and income perception were not found to be risk markers for physical or psychological violence in the current study. However, as expected, having a lower education level and currently being single was associated with higher reports of past physical violence. The odds of experiencing psychological violence increased with the degree of importance a participant attached to religion and decreased with age. Furthermore, victims of more severe psychological violence were more likely to be single and less likely to have a good social support network.

Impact of IPV Victimization on Ethnic Minorities' Well-Being

Neither physical nor psychological IPV victimization was related to negative mental health outcomes, which is an unexpected finding compared to the large majority of studies documenting mental well-being of IPV victims. A possible explanation for the absence of an effect on mental health could be the nature of the health outcome. Cross-cultural research on well-being has demonstrated that in response to distress, non-Western cultures have a tendency to somatize whereas Western cultures are likely to psychologize (Beirens & Fontaine, 2011; Keyes & Ryff, 2003). Indeed, Beirens and Fontaine (2011) found that both Turkish immigrants and Turkish majorities reported higher levels of somatization compared to Belgian majorities. Hence, it could be that in the current study, IPV had no effect on victims' mental well-being but was expressed in the form of somatic symptoms. Unfortunately, the current study did not incorporate a somatic complaints scale that could examine the effect of IPV on somatization. The lack

of effect of IPV on mental health can additionally be explained by cultural differences regarding the shape, expression, and intensity of emotions (Markus & Kitayama, 1991). Emotional processes are influenced by the cultural view of the self (Kitayama, Park, Sevincer, Karasawa, & Uskul, 2009). Kitayama and colleagues (2009) have argued that Western cultures accentuate a view of the self as *in*dependent while non-Western cultural contexts emphasize a view of the self as *inter*dependent. According to this interdependent view of the self, the expression of adverse individual feelings such as mental difficulties does not contribute to social harmony. Consequently, individuals are directed to restrain their inner feelings and to avoid the expression of negative emotions.

The interpersonal context (i.e., the self in relation to the other) is focal among people with an interdependent idea of the self, and this becomes clear when examining how violence at the hands of an intimate partner impacts on a victim's relational well-being. In general, the results concerning the association between IPV and relationship satisfaction are in line with the literature (e.g., Williams & Frieze, 2005) and add to the body of knowledge on gender differences in IPV relational outcomes (Caldwell et al., 2012). That is, lifetime experiences of violence by an intimate partner appear to have a negative impact on victims' relationship satisfaction. Women were more likely to be dissatisfied with their current relationship if they had ever experienced physical and psychological violence. Men were only more dissatisfied when they had experience of psychological violence. The present study also revealed higher levels of avoidant attachment orientation among female victims of physical and psychological victimization, whereas men scored higher on attachment anxiety if they had ever experienced physical violence. Given that individuals from interdependent cultures are inclined to judge themselves in terms of highly valued others (Markus & Kitayama, 1991), and that they tend to report higher levels of preoccupied attachment orientations (i.e., positive model of Other and negative model of Self; Schmitt et al., 2004), it is not

surprising that experiences with violence in a romantic relationship negatively impact on attachment orientation.

Finally, we found evidence for impaired sexual well-being at the relationship level if the participant had ever experienced IPV. The effects were most pronounced among female victims reporting psychological aggression. These women reported decreased levels of sexual satisfaction and sexual communication, and increased levels of sexual difficulties with and without distress. Physical IPV was associated with more sexual dissatisfaction and sexual difficulties with distress among both women and men. To the best of our knowledge, this study is among the first to examine IPV victims' sexual well-being at the relationship level in a population-based sample of Turkish immigrants. The observed gender differences indicate that, as is generally reported in the literature for other groups (e.g., Birnbaum, Reis, Mikulincer, Gillath, & Opraz, 2006), the relational context is more important for determining the sexual functioning of women than men. Furthermore, as no significant effect for sexual communication when experiencing physical violence was found for either men or women, this could possibly be explained from a cultural perspective on intimacy. It has been suggested that people in intimate relationships with more traditional gender roles are less likely to self-disclose on sexual matters (Marshall, 2008). Accordingly, it seems reasonable to assume that physical IPV experiences do not influence the extent to which IPV victims discuss their sexual whishes with their intimate partner. In conclusion, our findings indicate that IPV negatively affects victims' relational and sexual well-being within their current intimate relationship, and that the effect of IPV on the relational and sexual well-being is more negative for women than men.

Certain features of the present study are noteworthy. First, the prevalence estimates must be interpreted with caution. Prevalence numbers vary enormously according to the way data are collected. In line with most studies in this field, the current study reports on the findings of a self-report survey and it is important to

consider the limitations of this technique (Malley-Morrison & Hines, 2007). For this study, this implies that there might be an effect of community and cultural factors on the self-reporting rates of IPV victimization (White Yuan, Cook, & Abbey, 2013). These include that the violence must firstly be considered as non-normative. From a culture-specific gender role perspective, some Turkish women may accept a certain level of violence and some Turkish men may refuse to consider themselves as victims and thus do not regard their experiences as problematic (White et al., 2013). Additionally, some victims may have perceived themselves as victims but found it inappropriate to disclose this in a research context because IPV is a strictly private matter in certain cultures (e.g., Turkey; Yüksel-Kaptanoglu et al., 2012), and not a topic of conversation (White et al., 2013). Furthermore, although many forms of aggression do not appear to differ between immigrants and non-immigrants, it has been shown that immigrant women might face additional forms of psychological aggression (e.g., prohibition of wearing Western clothes; see Raj & Silverman 2002 for an overview). Therefore, to capture the full range of IPV experiences among ethnic minorities, some additional cultural-specific questions should be added to the standard measurements. Future research among ethnic minorities would therefore benefit from a mixed-method approach (i.e., qualitative *and* quantitative research) in order to consider the cultural norms, perceptions, beliefs, and socially acceptable behaviours within the community (Sokoloff & Dupont, 2005; White et al., 2013). For instance, Western Turkey is more economically and socially advanced than Eastern Turkey, which might reflect internal different lifestyles between the Turkish respondents in our sample (Yüksel-Kaptanoglu et al., 2012). Second, the data relied on a population-based sample and therefore presents mainly mild forms of aggression. Additional data from clinical research is necessary to get an idea of the extent of more severe forms of aggression and to examine how severe abuse impacts on the well-being of members of ethnic minorities. Third, the study is cross-sectional. Therefore, it is unclear from this data if IPV caused the health effects

that are examined, if the effects caused IPV, or – most probably – if the relationship is reciprocal. However, given the temporal order of the measurements in the current study (i.e., IPV in current/former relationship vs. current mental, relational, and sexual well-being), we considered the health effects as outcomes. Fourth, despite their theoretical relevance, both the attachment scale (ECR-S) and the sexual communication scale (DSC) proved to be weakly internally consistent in this study. These shortened versions were used in order to save time, but future research would benefit from using the full versions of these scales.

Despite these limitations, the present study expands the scope of current research by addressing the occurrence of IPV, as well as different aspects of victims' well-being, in an ecologically valid, population-based sample of an ethnic minority population. A further exploration of the association between IPV victimization, mental health, and relational and sexual well-being within ethnic minority victims' intimate relationships is essential in order to deepen our understanding of IPV and well-being, for organizing adequate prevention campaigns, and for allocating sufficient resources for helping immigrant victims.

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CHAPTER 5

INTIMATE PARTNER VIOLENCE VICTIMIZATION AMONG NON-HETEROSEXUALS: PREVALENCE AND ASSOCIATIONS WITH MENTAL AND SEXUAL WELL-BEING[1]

ABSTRACT

This study focused on intimate partner violence (IPV) among non-heterosexuals in Flanders. Prevalence rates for IPV were explored and compared with heterosexual IPV using a first representative sample consisting of 1690 heterosexuals and non-heterosexuals. A second convenience sample consisting of 2401 non-heterosexuals was used to determine differences between non-heterosexual women and men and to explore associations between IPV and victims' mental and sexual well-being. Physical and psychological IPV inflicted by the current/former partner were reported by 14.5% and 57.9% of the non-heterosexuals, respectively. Non-heterosexuals and heterosexuals were equally likely to report physical and psychological IPV and no differences were observed in the frequency of these acts. Furthermore, non-heterosexual women and men reported similar physical, sexual, and psychological IPV. However, compared to male victims, female victims experienced more frequent acts of psychological IPV. Psychological IPV was negatively associated with mental and sexual well-being. Sexual IPV was negatively associated with mental health but only among men.

[1] Based on Hellemans, S., Loeys, T., Dewaele, A., De Smet, O., & Buysse, A. (in press). Intimate partner violence victimization among non-heterosexuals: Prevalence and associations with mental and sexual well-being. *Journal of Family Violence*.

INTRODUCTION

Intimate partner violence (IPV) is defined as "behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours" (WHO, 2010, p.11). Saltzman, Fanslow, McMahon, and Shelley (2002) elaborated on this definition and explained that this type of violence can occur in heterosexual as well as non-heterosexual relationships. However, since research on IPV began in the 1970s, the majority of studies have focused almost exclusively on heterosexual dyads (i.e., male-against-female violence). Recently, a growing body of research has been gathered on IPV estimates within non-heterosexual dyads, demonstrating substantial prevalence of IPV among non-heterosexuals (see further). In order to work towards providing appropriate services for non-heterosexual victims of IPV, further empirical data on the prevalence and health correlates of IPV in this population is needed. Despite a sizable studies that have been published on this topic (for a review, see Murray & Mobley, 2009), some fundamental issues regarding IPV in non-heterosexual relationships remain unresolved. To date, studies discussing IPV in this population have mostly used convenience samples that make it difficult to draw conclusions that can be used for the general population (Balsam & Szymanski, 2005; Murray & Mobley, 2009). Furthermore, unlike physical and sexual IPV, psychological violence has received far less research attention. Last, compared to lesbian women, few available studies have documented information on IPV among gay men (e.g., Merrill & Wolfe, 2000). With these gaps in mind, the present study's primary objective consisted of exploring physical as well as psychological IPV prevalence rates among non-heterosexual women and men in a large representative and population-based sample of Flemish (non-) heterosexuals. Using a

second large-scale convenient sample consisting of predominantly non-heterosexuals, this study was developed to elaborate on IPV differences between non-heterosexual women and men, and to explore its health correlates. Bringing together both data sources enabled us to explore differences between a heterosexual and a non-heterosexual population as well as within a non-heterosexual population.

Prevalence Research

Most of the studies discussing aggression in non-heterosexual relationships have primarily focused on prevalence rates. Similar to in research on IPV among heterosexuals, differences in sample design and IPV conceptualization have led to large discrepancies in the prevalence estimates between the various studies (Krahé, Bieneck, & Möller, 2005). Additionally, the conceptualization of sexual orientation influences the IPV prevalence rates recorded by different studies. Most studies on sexual minorities have only assessed sexual self-identification (Priebe & Svedin, 2012). However, defining sexual orientation as a multidimensional construct (i.e., including identity, attraction, and behaviour) may provide a more accurate indication of human sexuality and is therefore recommended in research (Laumann, Gagnon, Michael, & Michaels, 1994; Murray & Mobley, 2009; Priebe & Svedin, 2012). For example, a study by Stefansen, Hegna, Valset, von Soest, and Mossige (2009) on violence against young homosexuals revealed that for girls, same-sex attraction was associated with physical aggression and harassment whereas for boys, same-sex behaviour *without* same-sex attraction was more likely to be associated with violence. This indicates that vulnerability for victimization may be linked with several dimensions of sexual orientation. Therefore, we used a multidimensional approach to sexual orientation in our study and prefer to use the term “non-heterosexual” instead of “LGB”: Some people are classified as non-heterosexual even though they do not identify themselves as lesbian, gay or bisexual.

Overall, most prevalence studies have used an exclusive non-heterosexual sampling design (e.g., Balsam, Beauchaine, & Rothblum, 2005; Burke, Jordan, & Owen, 2002; Carvalho, Lewis, Derlega, Winstead, & Viggiano, 2011; Descamps, Rothblum, Bradford, & Ryan, 2000; Eaton et al., 2008; Halpern, Young, Waller, Martin, & Kupper, 2004; Matte & Lafontaine, 2011; McKenry, Serovich, Mason, & Mosack, 2006; Renzetti, 1989). Only a few have included a heterosexual comparison group to examine differences or similarities between non-heterosexual and heterosexual IPV (e.g., Freedner, Freed, Yang, & Austin, 2002; Messinger, 2011).

Heterosexual versus non-heterosexual IPV. Studies that document IPV prevalence rates of non-heterosexual aggression or those comparing non-heterosexual and heterosexual relationships, have reported mixed results. Whereas some have found higher rates for heterosexuals than non-heterosexuals (Balsam et al., 2005; Messinger, 2011), most have reported similar prevalence estimates in heterosexual and non-heterosexual relationships (Alexander, 2002; Freedner et al., 2005; Potoczniak, Mourot, Crosbie-Burnett, & Potoczniak, 2003). In their methodological review about same-sex IPV, Murray and Mobley (2009) observed that approximately one quarter to half of same-sex intimate relationships show abusive dynamics, which is comparable to the rates of heterosexual IPV. Based on 19 studies, Burke and Follingstad (1999) presented prevalence rates specifically for physical IPV ranging from 8.5% up to 48% among non-heterosexual partners. Despite the interesting findings of the latter review, most of the studies focused exclusively on physical and sexual IPV, whereas only a few examined the prevalence of psychological IPV. There is a particular gap in the knowledge about psychological aggression where gay men are concerned (Stephenson, Rentsch, Salazar, & Sullivan, 2011; Turell, 2000). Furthermore, the few studies that exist in the field only report on results based on convenience samples. Consequently they cannot be considered as "true" prevalence rates. To counter this limitation, Messinger (2011) examined IPV in non-heterosexuals in a nationally representative sample in the U.S. (*N* =

14 182). This study showed that respondents with a history of same-sex relationships were twice as likely to report verbal aggression (69%), controlling behaviours (77%), physical aggression (36%), and sexual aggression (11%) in their relationships than those with exclusively heterosexual relationships. As in Messinger's study, our first research question (RQ1) concerned the examination of physical and psychological IPV prevalence estimates among non-heterosexuals in a representative sample.

Non-heterosexual women versus non-heterosexual men. For non-heterosexuals, there is more literature on prevalence rates of IPV in lesbian relationships than there is about gay relationships (e.g., Merrill & Wolfe, 2000). This is due to the fact that violence against women is an issue of interest for feminists (Burke & Follingstad, 1999) although the overwhelming focus of research on HIV among gay men also plays a role here (Merrill & Wolfe, 2000). Therefore, studies comparing non-heterosexual women and men are almost nonexistent (Waldner-Haugrud, Vaden Gratch, & Magruder, 1997). Some hypotheses have been formulated to describe that IPV is more prevalent among lesbian women than among gay men (e.g., Turrell, 2000) but no valid conclusions have been drawn. A study by Waldner-Haugrud et al. (1997) has found that lesbians are more likely to be victims as well as perpetrators of physical IPV compared to gay men, but when examining the severity of these acts, no differences were found.

Theoretical Explanations for IPV Among Non-heterosexuals

General theories, based on research in heterosexual relationships, are often applied to explain IPV in non-heterosexual relationships (Balsam & Szymanski, 2005; Burke & Follingstad, 1999; McClennen, 2005; Murray, Mobley, Buford, & Seaman-DeJohn, 2006). These theories mainly focus on gender differences but one of the characteristics that distinguishes between heterosexuals and non-heterosexuals is that in the latter, the partners' gender does not determine the role they perform (Schechory

& Ziv, 2007). To date, no clarity exists on the extent to which (a) non-heterosexual IPV can be explained by the same (gender-based) theories used to explain heterosexual IPV, and (b) specific dynamics inherent to same-sex relationships influence same-sex IPV.

Overall, and with respect to the first ambiguity, IPV is a complex phenomenon and has to be understood from a multifactorial perspective (Stith, Smith, Penn, Ward, & Tritt, 2004). Heterosexual IPV has commonly been explained by biological (i.e., aggression as a human instinct), psychological (i.e., aggression as learned behaviour, as personality characteristic), and socio-cultural theories (i.e., power and control dynamics). According to Burke and Follingstad (1999), these theories can be used to support dissimilarities as well as similarities between heterosexual and non-heterosexual IPV (for a detailed review see Burke and Follingstad, 1999). For example, IPV has often been linked to unequal power dynamics and a loss of control in the relationship (Johnson & Ferraro, 2000). Power and control dynamics have mainly been identified as critical factors in heterosexual IPV because of its association with the dominant role of men in our society. According to this heteronormative view, IPV should be more prevalent among heterosexuals than non-heterosexuals. Using the concepts of power and control dynamics in non-heterosexual relationships is challenging as some research has stated that non-heterosexual relationships are more egalitarian than heterosexual relationships (Shechory & Ziv, 2007). Limited research has focused on these power and control dynamics among non-heterosexual couples but evidence has been found that victimized lesbians report remarkably less control and decision making authority in their relationships than their not victimized counterparts (Eaton et al., 2008). A proposed explanation from a gender-based perspective is that lesbian perpetrators report overall higher masculinity traits. This leads us to the second ambiguity.

Although some "causes" of aggression in non-heterosexuals fit within these gender-based heterosexual theories, it is important to consider that there may also be some specific IPV dynamics that are inherently relevant to men who have relationships with men, and women who have relationships with women. For example, it is possible that not only gender but also sexual orientation are directly related to unequal power and control dynamics (Miller, Greene, Causby, White, & Lockhart, 2001). Non-heterosexual victims/perpetrators may experience a sense of "loss of control" while they remain "in the closet" and lack a clear identity to present to others. Or, when a person is open about his/her sexual orientation, a lack of control may also be experienced in other aspects of their lives as they cope with reactions of family and friends, and changes in their work environment. Furthermore unlike heterosexuals, non-heterosexual women and men have to cope with additional stressors such as minority stress (i.e., stress that is derived from being a member of a minority group; Dewaele, Van Houtte, Cox, & Vincke, 2013; Meyer, 1995). An excess in prevalence of mental disorders is explained through this concept of minority stress. The latter explains how stigma, prejudice, and discrimination create a hostile and stressful social environment that causes mental health problems. The model describes stress processes, including the experience of prejudice events, expectations of rejection, hiding and concealing, internalized homophobia, and ameliorative coping processes. Recent studies have acknowledged the role that minority stress can play in intimate relationships (Balsam & Szymanski, 2005; Mohr & Daly, 2008; Rostosky, Riggle, Gray, & Hatton, 2007). Being in a romantic relationship with a same-sex partner can generate additional stressors such as experiences with discrimination, making the relationship more vulnerable to increased conflict (Frost, 2011) and IPV experiences (Alexander, 2002).

Overall, it is clear that explaining IPV among non-heterosexuals is complex and that multiple theories can be used to clarify differences or similarities with heterosexual

IPV. The present study did not allow us to test these different theoretical perspectives, but there is no clear argument to expect that IPV among non-heterosexuals would be more or less prevalent than among heterosexuals when coming from a gender-based theoretical perspective. In the current study we therefore aimed to explore whether IPV among non-heterosexuals is equally, less, or more prevalent relative to levels observed in heterosexual relationships (RQ2). Further, specific theories on IPV among non-heterosexuals have not yet yielded empirical evidence for differences in vulnerabilities among non-heterosexual women and men. Therefore, our third research question (RQ3) explored whether IPV in non-heterosexual women is equally, less, or more prevalent relative to IPV among non-heterosexual men.

Health Correlates of IPV

Studies on the health correlates of IPV have consistently found an adverse effect of IPV on victims' mental health (Campbell, 2002; Coker et al., 2002). However, most of these studies have investigated these associations in heterosexual samples of women reporting physical aggression (Krahé et al., 2005). As such, several associations have received little empirical attention. These include associations between psychological aggression and health outcomes (Follingstad, 2009), and associations between IPV and victims sexual well-being (Coker, 2007). Furthermore, studies examining these associations in a sample of non-heterosexuals are even less common.

Mental well-being. Some research attention has been devoted to mental health outcomes for non-heterosexuals reporting IPV (e.g., Descamps et al., 2000; Distefano, 2009; Houston & McKirnan, 2007; Morris & Balsam, 2003). For example, in a sample of 817 men who have sex with men, Houston and McKirnan (2007) found that IPV victims were more likely to report mental health problems (e.g, depression, bipolar disorder, emotional disorder). Descamps et al. (2000) reported that lesbians with an IPV history, reported significantly more daily stress, and increased rates of depression and alcohol

abuse. Given that aggression by an intimate partner is strongly associated with mental health problems, it is important to expand research on these associations for non-heterosexual victims. In particular the association between psychological aggression and mental health correlates deserves more research attention. The current study aimed to assess the association between the different types of IPV and mental health among non-heterosexual women and men (RQ4). We predicted that higher scores of IPV would be associated with lower levels of mental health for both non-heterosexual women and men.

Sexual well-being. Relationship research has found evidence for an association between relational and sexual well-being. Sexual well-being refers to a satisfying sexual relationship characterized by satisfaction with the quality and frequency of sex, and by the absence of sexual dysfunction (Bodenmann, Ledermann, & Bradbury, 2007). Recently, there has also been a growing interest in research on the interpersonal dynamics of sexual (dys)function (for a review, see Dewitte, 2012). For example, studies have shown that experiencing relationship problems (e.g., tension and conflict) is associated with lower sexual satisfaction, a greater likelihood of sexual dysfunction, and is one of the most important predictors for sexual distress among women (Bodenmann et al., 2007; Metz & Epstein, 2010; Oberg & Fugl-Meyer; King, Holt, & Nazareth, 2007; Stephenson & Meston, 2010). Metz and Epstein (2002) assessed the specific role of relationship conflict in sexual dysfunction and proposed different pathways for the association between relationship conflict, and sexual dysfunctions. One of these paths assumes that relationship conflict can (directly or indirectly) lead to sexual dysfunction. More specifically, they argue that a relationship characterized by conflict, power and control dynamics, leads partners to protect themselves from being abused or controlled. Sexually, they will therefore focus on self-protection and control, rather than on intimacy with their partner. Although the authors do not provide information on how these relationship dynamics may be linked to different types of dysfunction, they

emphasize that relationship dynamics may influence different phases in sexual responses (e.g., sexual desire, arousal, intimate behaviour).

Despite the recent interest in relationship dynamics and sexual function, research on the association between IPV and sexual function is still scarce. To date, IPV research has mainly focused on the association with sexual risk-taking behaviours rather than the sexual function for couples reporting IPV and, to the best of our knowledge, this has not yet been tested among non-heterosexuals. Coker (2007) reviewed the role of physical IPV on sexual function in heterosexual women and reported associations with inconsistent condom use, partner non-monogamy, sexually transmitted diseases, unwanted pregnancies and abortion, dyspareunia, and lack of sexual pleasure. A distinct deficit has been noted on research on the topic of sexual satisfaction and sexual dysfunctions (for a review, see Coker, 2007). Therefore, the current study aimed to assess the association between physical, psychological, and sexual IPV and sexual functioning among non-heterosexual women and men (RQ5). We hypothesized that non-heterosexuals reporting IPV, would report lower levels of sexual satisfaction, less satisfaction with the frequency of sex, and more sexual distress. Further, as relationship variables are more likely to be linked with sexual functioning among women than men (Metz & Epstein, 2002), we expected stronger associations between IPV and sexual well-being among women than men.

METHOD

Participants and Procedure

Sample I. This sample drew on data from the survey "Sexual Health in Flanders" (Buysse et al., 2013), a large-scale representative survey on sexuality, sexual health and relations in Flanders. The survey contained extensive information on sexual health

characteristics and bio-medical, psychological, demographic, and socio-cultural correlates. Respondents between 14 and 80 years of age were included. Data were collected between February 2011 and January 2012. Our sample consisted of 1832 respondents (response rate: 40.0% of the eligible respondents), who were randomly drawn from the Belgian National Register. In order to enhance statistical power in each of the three pre-defined age categories, we stratified the sample into three equally large parts: one-third consisted of young respondents (aged 14 to 25), one-third of middle-aged respondents (aged 26 to 49), and one-third of respondents aged between 50 and 80 years old. After data collection, the data were weighted by gender, age, and educational level. Data were gathered via face-to-face interviews, along with a combination of computer-assisted personal interviewing (CAPI) and computer-assisted self-interviewing (CASI). To describe in more detail, all sensitive information (i.e., a wide range of sexual health characteristics) was gathered in a CASI set-up, so that respondents never had to share private information about their sexual health with an interviewer. In this sample, we report on adult heterosexuals (≥ 18 years, *n* = 1571) and non-heterosexuals (≥ 18 years, *n* = 119). The mean age of heterosexual respondents was 46.15 years (*SD* = 16.70, Range: 18–79). The mean age of non-heterosexual respondents was 44.34 years (*SD* = 17.32, Range: 18–80). Most women (80.2%) and men (82.2%) were in a romantic relationship. See Table 1 for a detailed overview of this sample's characteristics.

Sample II. The second sample drew on data from the survey "Click out of the bedroom", a large-scale convenience sample on sexuality, sexual health, and relations in sexual minorities in Flanders. This survey is similar to the survey in sample I, but was developed to be significantly shorter in order to minimize respondent drop-out. We collected data between September 2011 and March 2012 by setting up a target sampling design followed by a web survey. Web surveys offer a highly accessible way to pose delicate questions anonymously and are therefore suitable to reach sexual

minorities without jeopardizing their status as a hidden population (Dewaele & Van Houtte, 2010). However, these techniques are known for inducing self-selection bias. In order to recruit a relatively diverse sample, we used a variety of recruitment channels and methods (e.g., Facebook, flyers, lesbian, gay and bisexual parties, advertisements in the written press, electronic mailings). The final database consisted of 3702 individuals (66.9% lesbians, gays or bisexuals). In this study, we only report on adult non-heterosexual women (≥ 18 years, *n* = 883) and non-heterosexual men (≥ 18 years, *n* = 1518). The mean ages for female and male respondents were 30.53 years (*SD* = 11.5, Range: 18-86) and 35.31 years (*SD* = 13.28, Range: 18-82), respectively. Sixty six percent of the women, and 57.8% of the men were in a romantic relationship. Table 1 provides a detailed overview of the sample characteristics.

Table 1. Sample Characteristics of the Respondents in Sample I and Sample II

	Sample I				Sample II			
	Heterosexuals		Non-heterosexuals		Non-heterosexual women		Non-heterosexual men	
	(n = 1571*)*		*(n =* 119*)*		*(n =* 883*)*		*(n =* 1518*)*	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Age	46.15	16.70	44.34	17.32	30.53	11.5	35.31	13.28
	N	*%*	*N*	*%*	*N*	*%*	*N*	*%*
Gender								
Women	768	48.9%	86	71.7%	-	-	-	-
Men	803	51.1%	34	28.3%	-	-	-	-
Education level								
Student	74	4.7%	8	6.9%	311	35.3%	306	20.2%
No /primary / secondary school	460	29.4%	40	33.6%	36	4.1%	119	7.9%
High secondary school	570	36.4%	39	33.1%	134	15.2%	297	19.6%
High school	309	19.8%	23	19.4%	233	26.5%	424	28.0%
University	152	9.7%	8	7.0%	166	18.9%	367	24.3%
Romantic relationship								
Yes	1280	81.6%	90	75.3%	578	66.4%	866	57.8%
No	289	18.4%	29	24.7%	293	33.6%	632	42.2%

Note. Sample size varies across variables due to missing data.

Measures

Identical measures were used in Sample I and II to assess respondents' sexual orientation and IPV victimization.

Sexual orientation. In order to assess the number of non-heterosexual women and men in the general population, it is important to use an appropriate definition of sexual orientation (see Mercer et al., 2007; Kerker, Motashari, & Thorpe, 2006; van Kesteren, Hospers, & Kok, 2007). We conceptualized sexual orientation as a three dimensional construct measuring self-identification, sexual behaviour, and sexual desire (cf. Laumann et al., 1994). *Sexual self-identification* was assessed with the question: "How would you identify yourself?". Respondents could answer on a 5-point Likert scale

(i.e, straight, more straight than gay/lesbian, bisexual, more gay/lesbian than straight, gay/lesbian). An open-end response category was added for respondents who did not identify with any of these labels (referred to as "other"). *Sexual behaviour* was measured in two steps. First respondents were asked "How many people have you had sex with in your life?" (open-ended question) and then we asked respondents "Were these people men, women, or both?" (answers ranged from 1 = *exclusively women* to 5 = *exclusively men*). *Sexual desire* was also assessed using two questions: "Do you sexually fantasize about men, women, or both?" and "Do you feel sexually attracted to men, women or both?". Respondents could answer these questions on a 5-point Likert scale (from 1 = *only about / to women* to 5 = *only about / to men*). Furthermore, respondents could answer these questions with "about/ to neither". With the information from these four items, we created a dichotomous variable categorizing respondents as non-heterosexual (= 0) or heterosexual (= 1) when they reported identifying as gay/lesbian, bisexual, or more gay/lesbian than straight, or when they reported having had at least as many same-sex sexual fantasies as opposite-sex fantasies, or when they reported feeling attracted to the same-sex at least as often to as to the opposite-sex, or when they reported having had at least as many same-sex sexual contacts as opposite-sex sexual contacts.

Intimate partner violence. In the present study, IPV is defined as self-reported physical and psychological victimization by a current or former partner. Physical IPV was assessed with one question measuring different acts of physical aggression (adapted from the Conflict Tactics Scale, CTS; Straus, 1979). Respondents were asked "If you think about your current or former partner, has he/she ever hit you with the flat of their hand, hit you with their fist, kicked you, or physically hurt you in another way?". This question was rated on a 5-point Likert scale (from 0 = *never* to 4 = *very often*).

To assess psychological IPV, we adopted and modified items from the WHO Multi-country Study on Women's Health and Domestic Violence against Women (Garcia-

Moreno, Jansen, Ellsberg, Heise, & Watts, 2005). Respondents were asked "If you think about your current or former partner, has he/she ever..." followed by seven items: (a) "tried to limit the contact you have with your friends or family members", (b) "insisted on knowing your whereabouts and who you were with at every moment of the day", (c) "ignored you or treated you indifferently", (d) "criticized you or ridiculed you for what you do or say", (e) "belittled or humiliated you in front of other people", (f) "intentionally done something to scare or intimidate you", and (g) "threatened you to hurt you or someone you love". The seven items were rated on a 5-point Likert scale (from 0 = *never* to 4 = *very often*). As a Principal Component Analysis based on the eigenvalues revealed in both studies a single factor solution with approximately equal weights for all items, a scale for the psychological aggression was computed by summing the scores for each item, with a higher score indicating more severe psychological IPV (Range: 0-28). The seven-item measure was reliable in sample I (α = .87) and sample II (α = .83).

In sample II only, sexual IPV was assessed. The question "If you think about your current or former partner, has he/she ever forced you to do sexual things that you did not want?" was rated on a 5-point Likert scale (from 0 = *never* to 4 = *very often*).

Mental health. As a measure of mental health, we used the shortened version of the Mental Health Inventory (MHI; Veit & Ware, 1983). The MHI-5 consists of five items (e.g., "Over the past four weeks, how much of the time were you a happy person?") assessing persons' current mental health status. All items were scored on a 6-point Likert scale (from 0 = *never* to 5 = *all the time*). The MHI-5 has a minimum score of 0 and a maximum score of 25. Higher scores are indicative of greater psychological well-being and an absence of psychological distress over the past four weeks. The psychometric properties of the MHI-5 are supported (Marques, Pais-Ribeiro, & Lopez, 2011) and the reliability and validity are methodologically sound (Strand, Dalgard, Tambs, & Rognerud, 2003). The alpha reliability for the MHI-5 in this study was .87.

Sexual satisfaction. As a measure of sexual satisfaction over the past six months, respondents were asked two questions: "In general, how satisfied are you with your sex life?" and "How satisfied are you with the frequency you had sex in the past six months?". The two questions were scored on a 5-point Likert scale (from 1 = *very unsatisfied* to 5 = *very satisfied*).

Sexual dysfunctions. To assess sexual difficulties and sexual distress associated with sexual difficulties, the Sexual Functioning Scale (SFS; Enzlin et al., 2012) was used. Respondents were asked to what extent they experienced range of sexual problems (e.g., increased/decreased spontaneous or responsive sexual desire, arousal dysfunction, orgasmic dysfunction, dyspareunia, vaginismus, retrograde ejaculation, and a lack of a forceful propulsive ejaculation) in the past six months. All sexual difficulties were rated on a 4-point scale (from 1 = *no* to 4 = *severe or extreme*). Furthermore, respondents were asked to evaluate how distressing each sexual difficulty was for themselves and if applicable, for their partner, and for their relationship. Each type of distress was scored 1 (= *no or mild distress*), 2 (= *moderate distress*), or 3 (= *severe or extreme distress*). If respondents had a sum score of ≥ 2 when not in a relationship or ≥ 5 when in a relationship (i.e., moderate levels of distress in at least two of three domains), distress was considered to be present. For the current study, a sexual dysfunction scale was computed with three levels (0 = *no dysfunction*, 1 = *one or more difficulties without distress*, 2 = *one or more difficulties with distress*).

Sample I and II Characteristics

Respondents in *sample I* were identified as non-heterosexual (7.1%, *n* = 119) when they reported to *identify* as lesbian, gay, bisexual or more lesbian, gay than straight (3.2%), or when they reported having had at least as many same-sex sexual *fantasies* as opposite-sex fantasies (5.2%), or when they reported feeling *attracted* to people of the same-sex as at least as often as to the opposite-sex (3.3%), or when they reported

having had at least as many same-sex sexual *contacts* as opposite-sex sexual contacts (2.0%). No differences were found between the heterosexuals and non-heterosexuals for the socio-demographic characteristics age, $t(1688) = 1.14$, $p = .26$, educational level, $\chi^2(4) = 3.04$, $p = .55$, and being in a romantic relationship, $\chi^2(1) = 2.56$, $p = .11$) (see Table 1).

Of the non-heterosexuals in *sample II* ($n = 2401$), 93% identified as lesbian, gay or more bisexual than straight, 96.7% had at least as many same-sex sexual *fantasies* as opposite-sex fantasies, 95.3% reported feeling *attracted* to the same-sex as at least as often as to the opposite-sex, and 88.5% reported having had at least as many same-sex sexual *contacts* as opposite-sex sexual contacts. Non-heterosexual women and men differed in terms of the socio-demographics factors age, $t(2399) = 8.94$, $p < .001$), being in a romantic relationship, $\chi^2(1) = 16.92$, $p < .001$, and educational level, $\chi^2(4) = 75.28$, $p < .001$. Overall, in comparison to non-heterosexual men, more non-heterosexual women were in a romantic relationship at the time of the survey. Non-heterosexual women also tended to be younger than the men surveyed and there were more non-heterosexual women who were still studying compared to non-heterosexual men (Table 1).

Statistical Analyses

Analyses were run in SPSS 20.0 and R 2.15. Univariate analyses were conducted to examine the prevalence of physical and psychological aggression among non-heterosexuals in a representative population sample (RQ1). In order to examine the role of sexual orientation in the prediction of physical and psychological IPV (RQ2) and to examine possible differences between non-heterosexual women and men in terms of physical and psychological IPV (RQ3), we used advanced count models that are specifically designed to analyze very (right) skewed counts. The standard model for analyzing count data is a *Poisson regression* but, a *negative binomial regression (NB)* is

recommended when the data is overdispersed (i.e., the variance of the counts is larger than the mean). Count data typically display a lot of zero observations and therefore zero-inflated extensions of these two models have been developed, namely the *zero-inflated Poisson model* and the *zero-inflated NB model* (see Atkins & Gallop, 2007; Karazsia & van Dulmen, 2010). Lately, two hurdle models have been developed to support a more transparent split of the distribution in zero-counts and non-zero counts, called a *Poisson logit hurdle model* and a *hurdle negative binomial model* (for a detailed explanation, see Loeys, Moerkerke, De Smet, & Buysse, 2012). More precisely, the probability of all non-zero counts relative to all zero-counts (i.e., the *zero-hurdle part*) is modeled using a binary logistic regression, while the frequency of all non-zero counts (i.e., the *counts part*) is modeled using a truncated Poisson or NB regression. In this setting, the *zero-hurdle part* examines the effect of a predictor (e.g., sexual orientation, gender) on the likelihood of experiencing IPV and the *counts part* examines the effect of this predictor on the frequency of IPV experiences among the victims. In both parts, regression coefficients are exponentiated (e^B) and are named odds ratios (*OR*s) and rate ratios (*RR*s), respectively. In percentages—100 x (e^B -1)—*OR*s reflect the percentage decrease (*OR* < 1) or increase (*OR* > 1) in the odds of experiencing IPV, whereas *RR*s reflect the percentage decrease (*RR* < 1) or increase (*RR* > 1) in the expected frequency of IPV experiences for each unit increase in the independent variable, controlling for the other predictors in the model.

First, we explored which model (Poisson, NB, hurdle Poisson, or hurdle NB model) best fitted with the dependent variables, physical and psychological IPV, in our first sample. Each of these count models included gender, age, education, sexual orientation, and gender x sexual orientation (to assess for potential differences between heterosexuals and non-heterosexuals according to gender) as independent variables. Using graphs and statistical tests (outlined in Atkins & Gallop, 2007; Loeys et al., 2012), it was found that the *NB model* best fitted the observed distribution of physical IPV and

that the *hurdle NB model* (further referred to as NBLH) best fitted the distribution for psychological IPV (see Figures 1A and 1B). These preliminary analyses revealed no significant effect of gender x sexual orientation and therefore, the interaction term was excluded in further models. To examine possible differences between non-heterosexual women and men in terms of physical and psychological IPV (RQ3) in the second sample, the same count models were used. In addition, evidence was found that the *NB model* best fitted the distribution of sexual IPV (see Figures 2A to 2C).

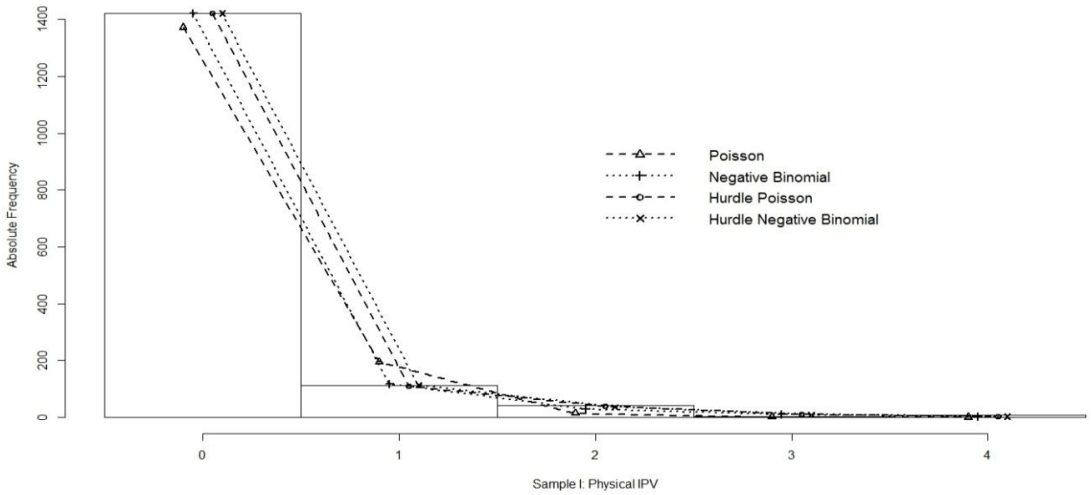

Figure 1A. Histogram of Physical IPV Experiences with Predicted Frequencies from Different Types of Count Regressions (Sample I)

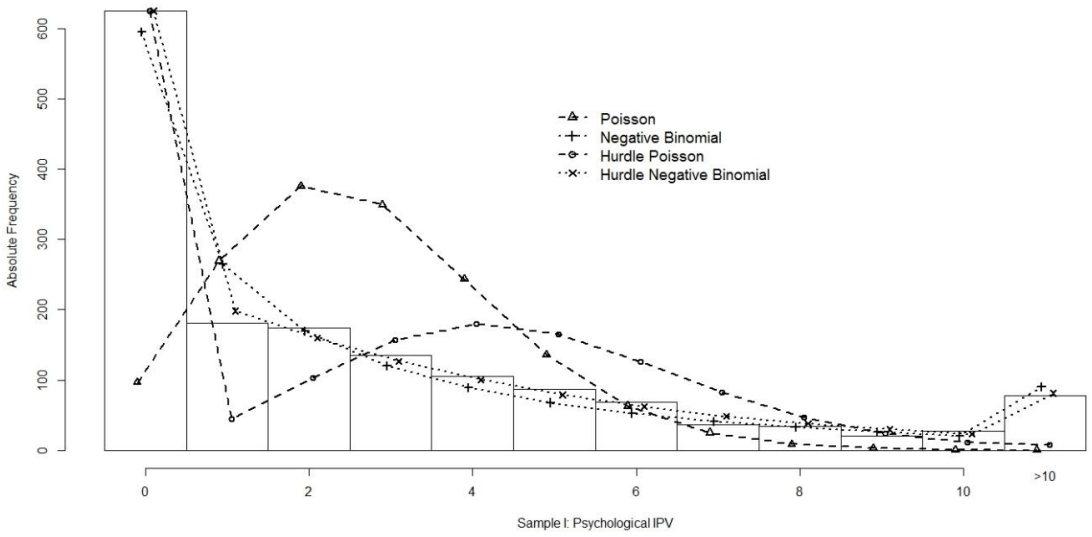

Figure 1B. Histogram of Psychological IPV Experiences with Predicted Frequencies from Different Types of Count Regressions (Sample I)

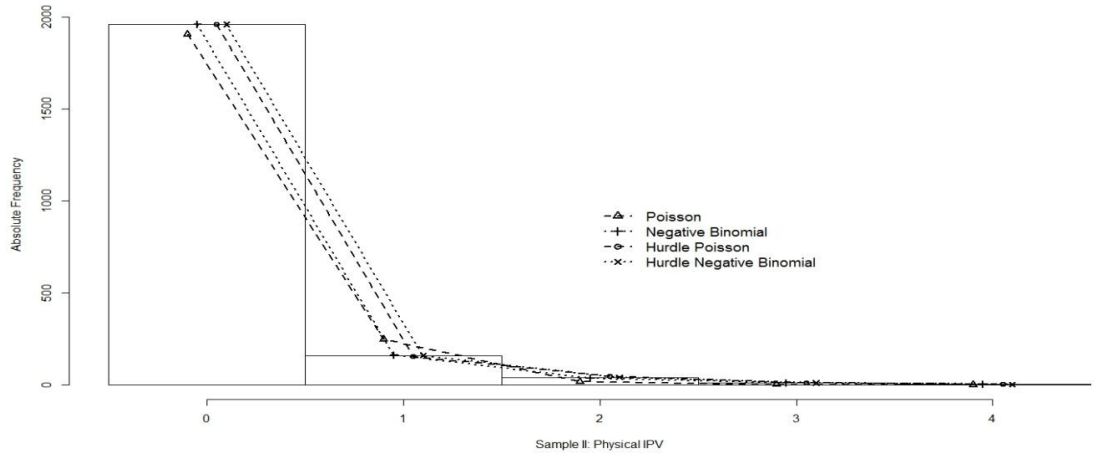

Figure 2A. Histogram of Physical IPV Experiences with Predicted Frequencies from Different Types of Count Regressions (Sample II)

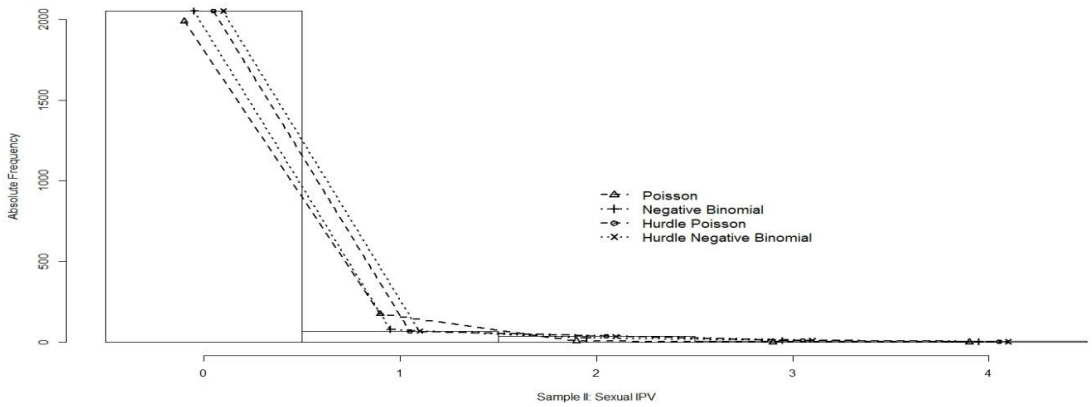

Figure 2B. Histogram of Sexual IPV Experiences with Predicted Frequencies from Different Types of Count Regressions (Sample II)

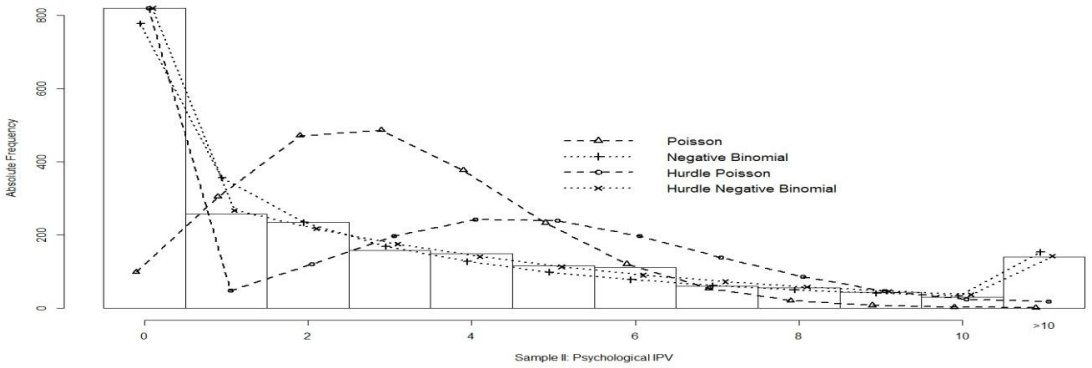

Figure 2C. Histogram of Psychological IPV Experiences with Predicted Frequencies from Different Types of Count Regressions (Sample II)

RESULTS

IPV Prevalence Among Non-heterosexuals (RQ1; Sample I)

Table 2 demonstrates that prevalence rates for physical and psychological IPV were high but when the frequency of these acts is examined, the scores indicate low to moderate occurrence of physical and psychological aggression by the current or former partner among non-heterosexual respondents. Overall, physical IPV was reported at least once by 14.5% of the non-heterosexual respondents. Further, Table 2 indicates that 57.9% of the non-heterosexuals reported at least one act seldom (out of seven) of psychological IPV by their current or former partner. The most commonly reported acts of psychological IPV among non-heterosexuals included being criticized for what [you] do or say, being ignored or threat indifferently, and being belittled or humiliated in front of other people. The least prevalent act of psychological IPV was that of threats made to hurt a loved one.

Table 2. Descriptive Statistics and Frequencies of Lifetime IPV Victimization (Sample I)

Physical IPV	*M (SD)*	*%*
Hit you with the flat of their hand, with their fist, kicked you or physically hurt you in another way	.23 (.63)	14.5%
Psychological IPV	3.16(4.29)	57.9%
Tried to restrict your contact with family and friends	.43(.79)	26.5%
Insisted upon knowing your whereabouts every moment of the day	.59 (1.01)	30.8%
Ignored you and treated you indifferently	.57 (.79)	41.5%
Criticized you or ridiculed you for what you do or say	.69 (.87)	47.9%
Belittled or humiliated you in front of other people	.46 (.73)	33.6%
Intentionally done something to scare or intimidate you	.26 (.76)	13.0%
Threatened to hurt either you or someone you love	.15 (.63)	7.8%

Note. IPV = intimate partner violence.

IPV Among Non-heterosexuals Relative to Heterosexuals (RQ2; Sample I)

As illustrated in Table 3, the output of the NB model for physical IPV showed no significant effects for the control variables, nor for sexual orientation. This means that – controlling for gender, age, education, and relationship status – non-heterosexuals and heterosexuals report on average the same frequency of physical IPV by their current or former partner.

After controlling for gender, age, education, and relationship status, the Hurdle NB model for psychological IPV revealed no significant effect for sexual orientation either in the zero-hurdle part, or in the counts part. This implies that non-heterosexuals are as likely as heterosexuals to report psychological IPV and that victims report no differences in frequency of psychological IPV (Table 3). In terms of the socio-demographic control variables, a significant effect was found in the zero-hurdle part for the control variables gender, age, education, and relationship status. More specifically, the chance of being psychologically victimized decreased by 27% when the respondent was female (relative male respondents), decreased by 1% for every unit increase in age, decreased by 36% if the respondent was in a current romantic relationship, and increased by 25% if they had a high level of education (relative to a lower education level). In the counts part, this regression revealed that the control variables relationship status and education level were significantly associated with the frequency of the psychological IPV experiences: Victims in a romantic relationship (relative to singles; *RR* = 0.65, a 35% decrease) and those who had a higher education level (*RR* = 0.76, a 24% decrease) reported less frequent acts of psychological IPV.

Table 3. Summary of Main Effects of the NB (physical IPV) and NBLH (psychological IPV) Models Testing Sexual Orientation and Socio-Demographic Control Variables (Sample I)

	Physical IPV	
Variables	*RR* (e^B)	95% CI
Gender[a]	1.21	[0.85, 1.72]
Age	0.99	[0.98, 1.00]
Education[b]	0.70	[0.49, 1.00]
Romantic relationship[c]	0.71	[0.47, 1.05]
Sexual orientation[d]	1.40	[0.78, 2.52]

	Psychological IPV			
	Zero-inflation part		Counts part	
Variables	*OR* (e^B)	95% CI	*RR* (e^B)	95% CI
Gender[a]	0.73**	[0.60, 0.90]	1.05	[0.91, 1.20]
Age	0.99***	[0.98, 0.99]	1.00	[0.10, 1.01]
Education[b]	1.25*	[1.00, 1.55]	0.76***	[0.66, 0.87]
Romantic relationship[c]	0.64***	[0.49, 0.83]	0.65***	[0.56, 0.76]
Sexual orientation[d]	0.92	[0.63, 1.36]	1.08	[0.84, 1.40]

Note. IPV = intimate partner violence; OR = odds ratios*; RR* = rate ratios*;* CI = confidence interval*.*

[a] Reference category is male; [b]Education level was recoded into education level lower than high school degree (reference category) and a high school degree or above; [c]Reference category is not being in a romantic relationship; [d]Reference category is a heterosexual sexual orientation.

** p* < .05*. ** p* < .01*. *** p* < .001*.*

IPV Among Non-heterosexual Women Relative to Non-heterosexual Men (RQ3; Sample II)

The NB model for physical IPV only showed one significant effect, namely for the control variable education. Respondents with a higher education level (relative to a lower education level) reported on average less physical IPV (*RR* = 0.43, a 57% decrease). The regression model showed no significant effect for gender, indicating that when controlling for the possible effects of the other variables non-heterosexual women and men reported the same frequencies of physical IPV (see Table 4).

The NB model for sexual IPV showed a significant effect for all variables except for gender. More specifically, the chance of experiencing sexual IPV increased by 1% for every unit increase in age, decreased by 43% for those with a higher education level (relative to lower levels), and decreased by 73% if the respondent was in a romantic relationship. The fact that no effect was found for gender indicates that controlling for all other variables, non-heterosexual women reported on average the same frequency of sexual IPV as non-heterosexual men (Table 4).

As illustrated in Table 4, the results of the NBLH model for psychological IPV showed that the odds of experiencing psychological IPV were significantly lower for those in an ongoing romantic relationship. Further, the counts part showed a significant effect for gender, age, romantic relationship level and education level. More specifically, the frequency of psychological IPV experiences significantly increased with increasing age, and was lower for more highly educated people and people in relationship. The frequency of psychological IPV among the victims increased by 15% for women (relative to men). This indicates that non-heterosexual women (relative to non-heterosexual men) are as likely to report psychological IPV, but that among the victims non-heterosexual women report more frequent acts of psychological aggression than non-heterosexual men.

Table 4. Summary of Main Effects of the NB (physical and sexual IPV) and NBLH (psychological IPV) Models Testing Gender Differences and Socio-Demographic Control Variables (Sample II)

	Physical IPV	
Variables	*RR* (e^B)	95% CI
Gender[a]	1.13	[0.83, 1.54]
Age	0.99	[0.98, 1.00]
Education[b]	0.43***	[0.31, 0.59]
Romantic relationship[c]	0.79	[0.58, 1.06]
	Sexual IPV	
Variables	*RR* (e^B)	95% CI
Gender	1.19	[0.77, 1.87]
Age	1.02*	[1.00, 1.04]
Education	0.57*	[0.36, 0.91]
Romantic relationship	0.27***	[0.17, 0.41]

	Psychological IPV			
	Zero-inflation part		Counts part	
Variables	*OR* (e^B)	95% CI	*RR* (e^B)	95% CI
Gender	0.86	[0.71, 1.03]	1.15*	[1.03, 1.30]
Age	1.01	[0.10, 1.01]	1.01***	[1.00, 1.01]
Education	0.96	[0.78, 1.19]	0.72***	[0.64, 0.81]
Romantic relationship	0.63***	[0.52, 0.76]	0.59***	[0.53, 0.66]

Note. IPV = intimate partner violence; OR = odds ratios; RR = rate ratios; CI = confidence interval.

[a] Reference category is male; [b]Education level was recoded into education level lower than high school degree (reference category) and a high school degree or above; [c]Reference category is not being in a romantic relationship; [d]Reference category is a heterosexual sexual orientation.

** p* < .05. *** p* < .01. **** p* < .001.

IPV and Mental Health

To examine the effect of physical, psychological, and sexual IPV on the current mental health of the non-heterosexual respondents (RQ4), a hierarchical linear regression analysis was used (view Table 5). To control for possible effects of socio-demographic characteristics on mental health, these variables (i.e., gender, age, educational level, and being in a romantic relationship) were entered in the first step of

the regression. In the second step, respondents' scores for physical IPV, psychological IPV, and sexual IPV were entered. In the third step, three interaction terms were entered to examine possible interaction effects between gender and the different types of intimate partner violence (i.e., Gender x Physical IPV, Gender x Psychological IPV, Gender x Sexual IPV). Non-significant interaction terms were removed from the final model. Prior to the regression analysis, collinearity diagnostics were performed using the variance inflation factors (VIF). No multicollinearity was evident as the VIF for the different types of IPV ranged between 1.04 and 1.56 (< 10; Cohen, Cohen, West, & Aiken, 2003). The final model was found to be significant, $F(8,2127) = -8.08$, $p < .001$ and accounted for 10.6% of variance in mental health scores. Physical IPV did not contribute significantly to the model while a significant effect was found for psychological IPV. Higher levels of psychological IPV corresponded with lower mental health scores. There was one significant interaction, involving Gender x Sexual IPV: While in men, increasing sexual IPV was associated with lower mental health scores, $\beta = -.17$, $p = .01$, no such association was found in women, $\beta = .03$, $p = .25$.

Table 5. Summary of Hierarchical Multiple Regression Analysis to predict Mental Health, Sexual Satisfaction, and Satisfaction with Frequency of sex from the Different Forms of Intimate Partner Violence (Sample II)

	Mental Health		Sexual Satisfaction		Satisfaction Frequency sex	
	ΔR^2	β	ΔR^2	β	ΔR^2	β
Step 1	.06		.08		.06	
Gender		-.05		.05*		-.06*
Age		.13***		-.05*		-.04
Educational level		.04*		-.03		-.03
Romantic relationship		.16***		.26***		.21***
Step 2	.04		.01		.02	
Physical IPV		-.03		-.01		.01
Psychological IPV		-.21*		-.11***		-.16***
Sexual IPV		-.17*		.03		.04
Step 3	.01		-		.01	
Gender x Physical IPV		-		-		-
Gender x Psychological IPV		-		-		.02*
Gender x Sexual IPV		.20**		-		-
Total R^2	.11***		.09***		.07***	
n	2136		1864		1864	

Note. IPV = intimate partner violence.
** p* < .05. *** p* < .01. **** p* < .001.

IPV and Sexual Well-Being

Our final research question concerned the association between IPV experiences and victims' sexual well-being (RQ5). Therefore, we examined the association between IPV and sexual satisfaction, satisfaction with the frequency of sex and sexual dysfunctions.

Association with sexual satisfaction and satisfaction with frequency of sex. A similar hierarchical regression analysis was also used to examine the effect of the different forms of IPV on respondents' sexual satisfaction (see Table 5). The same steps were followed as when predicting mental health scores (see above). Entering the interaction terms in step 3 did not significantly increase R^2. The final model without

interaction terms was found to be significant, $F(7, 1856) = 27.59$, $p < .001$ and accounted for 9.4% of the variance in sexual satisfaction. No significant association was found between either physical or sexual IPV, and sexual satisfaction. In contrast, a significant association was found between psychological IPV and sexual satisfaction. These results indicate that, in contrast to physical and sexual IPV, higher levels of psychological IPV were associated with lower levels of sexual satisfaction.

When predicting respondents' satisfaction in terms of the frequency of sexual activity over the past 6 months, the model was found to be significant, $F(8, 1855) = 17.43$, $p < .001$ and accounted for 7.0% of the variance in the satisfaction with the frequency of sex (see Table 5). Entering the interaction terms in step 3 did not significantly increase the explained variance. However, a significant interaction was found for Gender x Psychological IPV. Higher levels of psychological IPV were associated with lower levels of satisfaction with the frequency of sex for both men and women, but this was found to be slightly more pronounced in men, $\beta = -.14$, $p = .00$, than in women, $\beta = -.12$, $p = .00$.

Association with sexual dysfunctions. To assess to what extent IPV affects respondents' sexual functioning, we ran a multinomial logistic regression with the different IPV scores as predictors and sexual dysfunction as an outcome variable with three levels (0 = no dysfunction, 1 = difficulties without distress, and 2 = difficulties with distress). First, a full model was tested with gender, age, educational level, and being in a romantic relationship as control variables. The main effects (the three different IPV scores) and all interaction terms with gender were added to the model. Results revealed that the interaction terms did not significantly add to the overall fit of the model so they were removed from the final model. Multinomial logistic regression analysis was first performed with absence of sexual dysfunction as the outcome reference category (see Table 6). From our variables of interest, only psychological IPV was positively associated with sexual dysfunctions, $\chi^2(2) = 15.28$, $p = .00$; an increase of

one unit on psychological IPV increased the odds of sexual difficulties without distress versus no dysfunction with a factor of 1.05 [95% C.I. 1.01-1.08] and of a sexual difficulties with distress versus no dysfunction by a factor of 1.07 [95% C.I. 1.03-1.10]. No association was found between physical IPV, $\chi^2(2) = 1.32$, $p = .52$, or sexual IPV, $\chi^2(2) = 1.41$, $p = .50$, and sexual difficulties either with or without distress.

Table 6. Summary Multinomial Regression Analysis examining the likelihood of Sexual dysfunctions by level of Intimate partner violence (Sample II)

	B	SE	Wald[a]	*Exp(B)*
Sexual difficulties without distress' versus 'no dysfunction' [b]				
Male	.09	.13	.49	1.09
Age	.00	.01	.24	1.01
No degree/ only secundary school degree	.65***	.13	24.19	1.92
Romantic relationship[c]	-.07	.14	.29	.93
Physical IPV	.08	.16	.25	1.08
Psychological IPV	.04**	.02	6.29	1.05
Sexual IPV	-.06	.18	.11	.94
'Sexual difficulties with distress' versus 'no dysfunction' [b]				
Male	-.36**	.13	7.76	.70
Age	.00	.01	.41	1.00
No degree/ only secundary school degree	.33*	.15	4.99	1.38
Romantic relationship[c]	.59***	.13	19.83	1.81
Physical IPV	.17	.15	1.33	1.19
Psychological IPV	.06***	.02	13.56	1.07
Sexual IPV	.14	.15	.76	1.14

Note. IPV = intimate partner violence.
[a]df = 1; [b]Reference category is no dysfunction; [c]Reference category is not being in a romantic relationship.
** p* < .05. *** p* < .01. **** p* < .001.

DISCUSSION

The current study adds to the recent research extension for IPV in same-sex relationships by providing an in-depth exploration of the prevalence of IPV among non-heterosexual women and men. In contrast to most previous studies, the current study examined the prevalence of physical as well as psychological aggression by an intimate

partner in a large-scale representative population-based sample of (non-) heterosexuals. Furthermore, we aimed to explore whether IPV among non-heterosexuals is equally, less, or more prevalent relative to levels observed in heterosexual relationships. In addition to this, differences between non-heterosexual women and men, and health correlates of IPV were examined in a second large-scale convenience sample consisting of predominantly non-heterosexual persons.

As some reviews have already suggested (e.g., Burke & Follingstad, 1999; Murray & Mobley, 2009), IPV is a relatively frequent concern among non-heterosexuals. Our results indicate that about one in seven (14.5%) of the non-heterosexual respondents reported physical aggression at the hand of their current or former partner. Psychological aggression by the current or former intimate partner was reported by almost two thirds (57.9%) of the non-heterosexual respondents. Examining the average frequency, respondents generally reported low to moderate forms of physical and psychological IPV. As prevalence research is very sensitive to methodological choices, however, interpretation of these prevalence estimates and the comparison with other prevalence estimates should be approached with a certain level of caution. For example, where some studies include psychological aggression in their list of violent acts (e.g., Greenwood et al., 2002; Houston & McKirnan, 2007; Messinger, 2011), others only measure physical and/or sexual aggression (e.g., Kelly, Izienicki, Bimbi, & Parsons, 2011). Although some studies report one-year prevalence rates (e.g., Finneran, Chard, Sineath, Sullivan, & Stephenson, 2012), others provide five-year (e.g., Balsam et al., 2005) or lifetime prevalence rates (e.g., Freedner et al., 2002). Finally, while some studies use small (e.g., McKenry et al., 2006; Merrill & Wolfe, 2000) or large (e.g., Morris & Balsam, 2003; Stephenson et al., 2011) convenience sample, others recruit a population-based representative sample (Messinger, 2011; Halpern et al., 2004). In general, representative samples – such as the current study – tend to report somewhat lower prevalence estimates than self-selective convenience samples (e.g., Halpern et al., 2004;

Nielsen & Einarsen, 2008). Our estimates do indeed fall at the lower end of the prevalence spectrum, especially compared to some other studies (e.g., Burke et al., 2002) but, they are still in line with the overall reports of abusive dynamics in one quarter to half of all non-heterosexual relationships (Alexander, 2002; Murray & Mobley, 2009). Further, in concurrence with previous studies (e.g., Craft & Serovich, 2005; Merrill & Wolfe, 2000; Stephenson et al., 2011; Turrell, 2000), it was found that physical and psychological IPV tended to co-occur (r = .60, p < .001). However, there were far more respondents experiencing psychological IPV than physical IPV.

Our second research question concerned the examination of differences in IPV prevalence among non-heterosexuals and heterosexuals. We found that non-heterosexuals and heterosexuals reported on average the same frequency of physical aggression by their current or former intimate partner. Further, both groups were as likely to report psychological aggression and among the victims, no differences were found in the frequency of these reported acts. Although our findings partially contrast with the findings of Balsam et al. (2005), our results are compatible with most previous estimations (e.g., Alexander, 2002; Burke & Follingstad, 1999; Freedner et al., 2005; Potoczniak, Mourot, Crosbie-Burnett, & Potoczniak, 2003) .

Gender did not interact with sexual orientation for either physical or psychological IPV. This indicates that the role of sexual orientation in the prediction of IPV experiences does not differ for women and men. Compared to other studies, similarities (Owen & Burke, 2004; Morris & Balsam, 2003) as well as differences (Descamps et al., 2000) are noted. For example, based on their exploration of IPV among same-sex relationships, Owen and Burke (2004) noted no differences between heterosexual and lesbian women, although, they found IPV to be a greater problem for gay men compared to heterosexual men. The current study found no differences between heterosexual and non-heterosexual men, although we must be cautious with this interpretation as only thirty non-heterosexual men were included in this sample. The small number of non-

heterosexual men may have increased the possibility for a Type II error, which means that we may have missed a significant effect.

With regard to our third research question of to what extent IPV experiences differ within a sample of non-heterosexual women and men, we found some interesting results. Gender did not influence the probability of experiencing either physical or sexual IPV. In other words, non-heterosexual women were as likely to be subjected to acts of physical or sexual IPV by their current or former partner as non-heterosexual men. Slightly different results were found for psychological IPV. That is, men and women were equally likely to report being a victim, but female victims reported a higher incidence of violence than male victims. In terms of other studies comparing non-heterosexual women and men, the empirical literature offers inconsistent findings. According to some studies, IPV is more prevalent among lesbians than among gay men (e.g., Turrell, 2000; Waldner-Haugrud et al., 1997). Other studies, however, have suggested that IPV is more prevalent among gay men than among lesbians (e.g., Bryant & Demian, 1994; Burke et al., 2002) and others still have reported comparable rates (e.g., Carvalho et al., 2011). Again, methodological choices may partially explain the divergence in results among the different studies. A possible explanation for the finding by our current study that psychological aggression is more frequently experienced by female than male victims, may be derived from the lesbian concept *fusion* (Miller et al., 2001). Fusion refers to the formation of both intimacy and conflict dynamics within lesbian relationships. As a reaction to the dominance of a heteronormative culture, some lesbians want to stress the seriousness of their relationship by creating a very intense and intimate bond with each other. Consequently, they become highly dependent on each another. This high dependency makes them more vulnerable to conflict and IPV victimization/perpetration (Miller et al., 2001; Renzetti, 1989).

A fourth research question examined the relationship between IPV experiences and non-heterosexual victims' mental well-being. While increasing psychological IPV

was associated with lower mental health scores, no association was found for physical IPV. Therefore, one could mistakenly conclude that experiencing physical IPV does not affect respondents' mental health. Although post-hoc computed separate linear regressions did reveal an association between physical IPV and mental health, our results showed that when controlling for the different forms of IPV, only psychological IPV was significantly associated with respondents' mental health status. The meaning of this finding is twofold. First, it indicates that higher levels of psychological IPV are related to lower mental health scores. Second, it indicates that psychological IPV explains the largest amount of variance even if respondents also experienced physical or sexual IPV. This finding is consistent with a growing body of research specifically focusing on psychological IPV and its correlates (e.g., Follingstad, 2007, 2009). Researchers who have compared physical and psychological IPV in terms of health correlates found psychological aggression to be more mentally damaging than physical aggression (Follingstad, Rutledge, Berg, Hause, & Polek, 1990; O'Leary & Maiuro, 2001).

Furthermore, sexual victimization by the current or former partner was related to lower mental health scores, but only for men. A possible explanation for this result is that the nature of acts of sexual aggression among gay couples may differ from the sexual aggression that occurs within in lesbian relationships. Research examining the health outcomes of sexually abused victims, have consistently reported a more negative health outcome when the abuse involved penetration (e.g., forced anal sex) because of the severity of these acts (Browne & Finkelhor, 1986).

Our final research question examined the association between IPV experiences and non-heterosexual victims' sexual well-being. As expected, higher levels of victimization were negatively associated with sexual satisfaction and satisfaction with the frequency of sex, and positively associated with sexual dysfunctions. However, this only applied for psychological IPV. Experiencing a physical form of aggression does not seem to act as a precondition that affects one's sexual well-being. In contrast to our

expectations, these associations were not stronger for women than they were for men. These results add to the empirical literature that provides evidence that relationship problems are associated with people's sexual well-being (Metz & Epstein, 2002).

Strengths and Limitations

Several strengths, limitations, and implications need to be addressed. The current study relied on a representative sample of adult women and men in Flanders to examine the overall prevalence of IPV among non-heterosexuals. Consequently, addressing all (i.e., heterosexual and non-heterosexual) adult women and men rather than making a sample selection based on sexual orientation improved the generalizability of our results. Despite this, using a general population-based survey often means that sample sizes are not large enough to explore the variables in depth. Therefore, we used a second large-scale convenience sample with an overrepresentation of non-heterosexual women and men. Although respondents in this online population tended to be younger and more highly educated than respondents in our first representative sample, a methodological study on the comparison of these two data sources revealed almost no differences between the outcomes of the two data sources once age and educational level were controlled for (see Dewaele, Caen, & Buysse, 2013). Although both studies did target individuals rather than couples, it might be that a few couples were included by chance, but information on couples is missing. We assumed throughout this paper independent observations, and anticipate a very limited impact of ignoring non-independence in those small numbers of couples that were possibly recruited by chance.

Information on experiences with IPV is very sensitive. In our first and second sampling design, the use of CASI enhanced respondents to answer truthfully. In addition to this, the second sampling design has been shown to be a good format to encourage

stigmatized individuals to share sensitive information, especially for respondents who do not identify themselves as non-heterosexual to others.

Data on IPV are in general very skewed and exhibit a lot of zero observations. That is, most respondents report no IPV experiences and a "small" group of respondents report some instances of IPV. To deal with such skewed distributions, previous studies mainly used categorical statistical analyses (e.g., chi square statistics, binary/multinomial logistic regression analysis), yet, the measurement of IPV as a dichotomous or continuous variable has been found to impact on the results (Langhinrichsen-Rohling, 2010). Therefore, the current study used more advanced countmodels that respected the true distribution of our dependent variables.

Some limitations need to be addressed. First, this study is part of a large investigation into sexual health. Therefore, some items that are important to the IPV research were not included. For example, we did not asses for "threat of outing". Research has shown that this form of aggression is frequently reported by non-heterosexuals. Physical IPV was measured using a single question obtained from the Conflict Tactics Scale. Although the CTS has been utilized in a large number of studies on IPV, there have been several criticisms regarding this scale (e.g., McHugh & Frieze, 2006). One of them includes that it only measures a small number of violent acts. Though, there are many additional ways in which people can be physically hurt by a partner. It is possible that this partially contributes to an underestimation of physical and psychological IPV. Second, it should be noted that the current partner is not necessarily the perpetrator of all aggression experienced by a respondent. Therefore, we cannot be sure whether the poor mental and sexual well-being we document for some respondents is a long term outcome from aggression in the previous relationship, or whether it definitely directly linked with the current relationship. Third – and in line with the second limitation – the current study is based on a cross-sectional design. Therefore, no causal conclusions can be drawn and we have to be careful with *prediction*

statements. Although it might seem logical that a violent relationship might affect a person's well-being, an alternative hypothesis is that people with a low self-perceived mental health state are more prone and vulnerable to experiencing IPV (McKenry et al., 2006; Stith et al., 2004). A fourth limitation refers to the potentially cross-cultural differences related to experiences with IPV in non-heterosexuals. Some research points out that there are important cultural differences related to emotions, cognitive attributions, and symbolic selves between Northern Americans and Western Europeans (Kitayama, Park, Sevincer, Karasawa, & Uskul, 2009). Also, today, Belgium is one of the relatively few countries in the world that grants equal civil rights to same-sex partners. Although many Western-European countries are catching up (for a comparison between European countries, see Waaldijk & Bonini-Baraldi, 2006), we should beware that differences in the cultural and judicial climate might also affect experiences with IPV in same-sex partnerships. We therefore urge researchers to undertake studies which shed light on differences between being LGB in Western Europe versus Northern America. This could help us understand how minority stressors, cultural patterns, and impact on experiences with IPV might interact with each other.

Future Research and Implications

To conclude, our results add to the mounting evidence that many people, regardless of their sexual orientation, are at risk of experiencing IPV at some point in their lives. From our findings, it appears that IPV is as common both in terms of presence and frequency among heterosexuals and non-heterosexuals, and among non-heterosexual women and non-heterosexual men. This implies that researchers, policy makers, clinicians, and non-heterosexual IPV victims themselves must recognize IPV as a social concern in all kind of relationships, and not solely in heterosexual relationships.

As the body of research on this topic is still rapidly growing, it is not clear yet whether tackling this concern requires the same prevention campaigns and interventions as heterosexual IPV. However, some points of attention may help to acknowledge the existence of the problem and start the battle to diminish the number of cases of victims. First, a change in perception must be encouraged at the societal level. Although our results contradict the overall perception that IPV is more serious when it is directed from men towards women than from men towards men or women towards women (Seelau & Seelau, 2005), the lack of communication on this topic means that lesbians and gay men may not consider themselves as victims and that they may not respond to this violence. Therefore, a more gender-neutral and open conversation on the presence of IPV is same-sex relationships should be established. Second, more quantitative and qualitative research examining relationship dynamics in violent non-heterosexual relationships would lead to a greater in-depth understanding of this phenomenon. For example, the current study found that increased scores on psychological IPV were associated with lower levels of mental and sexual well-being. Possibly, these associations may be explained by a third variable, namely internalized homophobia. Research has found concrete evidence for a link between internalized homophobia and an array of both mental health issues (e.g., lower self-esteem, feelings of powerlessness, and self-destructive behaviour) and sexual dysfunctions (McKenry et al., 2006; Meyer, 2003). Further, internalized homophobia has also been linked to increased relationship stress and more IPV (Balsam & Szymanski, 2005). Therefore it is possible that experiences with IPV do not directly predict the health outcomes but that instead, internalized homophobia fully or partially explains this association.

To conclude, more public and research attention to IPV in non-heterosexual relationships would give clinical therapists the background knowledge and skills to provide a more equal treatment for all IPV victims, regardless of gender and sexual orientation.

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CHAPTER 6

GENERAL DISCUSSION

The goal of this doctoral dissertation was to gain insight in the prevalence of intimate partner violence (IPV) within different populations. Next to the examination of IPV victimization among heterosexual women and men, we were specifically interested in the extent to which Turkish ethnic minority women and men in Flanders, and non-heterosexual women and men experienced lifetime violence by an intimate partner. Although these two latter populations have been indicated as risk populations for experiencing IPV, they have not been extensively studied to date. Furthermore, we tried to get a better view on the association between IPV victimization and victims' well-being, by not only investigating their mental well-being but also their relational and sexual well-being within an intimate relationship. In this final chapter, we will briefly recapitulate the main goals of this doctoral dissertation and give an integrative overview of the most important findings. We will discuss implications with regard to theory, research, policy and clinical practice. Finally, we will describe some of the limitations and strengths of the conducted studies and formulate some suggestions for future research on IPV.

RECAPITULATION OF THE RESEARCH GOALS

The first objective of the current dissertation was to broaden our knowledge on the prevalence of IPV – specifically, common couple violence – among women and men in Belgium (Chapter 2) and in Flanders (Chapter 3). Special attention was given to IPV victimization among people from Turkish origin in Flanders (Chapter 4) and among non-heterosexuals (Chapter 5). This is because these populations have been suggested to be at increased or at least at equal risk for IPV victimization and have not been extensively studied with respect to intimate violence. Both annual (i.e., physical, psychological, sexual; Chapter 2) and lifetime (i.e., physical and psychological; Chapters 3 - 5) IPV prevalence rates were estimated based on several representative population-based samples.

The second aim was to clarify how past IPV victimization is – next to victims' individual mental well-being – related to victims' current well-being within an intimate relationship. Although clinical research suggests that IPV victimization shows a negative association with victims' relational well-being, empirical evidence on this link based on population-based samples remains limited. Especially research on the link between IPV and victims' sexual well-being in an intimate partner relationship is scarce. In an attempt to get more insight in the individual and relational correlates of IPV victimization, we examined the link between physical and psychological IPV and victims' current (a) mental health (Chapters 2 through 5) and (b) relationship satisfaction, attachment orientation, sexual satisfaction, sexual communication, and sexual dysfunction (Chapters 3 through 5).

INTEGRATION OF THE MAIN FINDINGS: OVERVIEW[1]

In the following paragraphs we will present the final results of our dissertation. First, we will discuss our findings on IPV prevalence estimates in representative samples and within specific samples, including a Turkish ethnic minority population and a sexual minority population. Second, we will present our results regarding the association between IPV victimization, mental health and a specific range of relational correlates. In both parts, we will discuss our findings with regard to gender differences.

[1] A general overview of the findings is reported in Table 1. In Chapter 5, no information was gathered on non-heterosexuals' current intimate partner relationships. Therefore, we did not measure relationship satisfaction and attachment orientation. Victims' sexual satisfaction and sexual dysfunction were assessed regardless of whether the respondents were in a current romantic relationship or not.

Table 1. Overview of the Main Findings on (a) IPV Prevalence Estimates and (b) Victims' Mental, Relational, and Sexual Well-Being

Chapter 2 (Belgian respondents)		Chapter 3 (Flemish respondents)		Chapter 4 (Turkish respondents)		Chapter 5 (Non-heterosexual respondents)	
Physical	1.3%	Physical	10.0%	Physical	14.3%	Physical	14.5%
Psychological	14%	Psychological	56.7%	Psychological	66.0%	Psychological	57.9%
Sexual	0.3%						
Physical	♀ = ♂	Physical	♀ = ♂	Physical	♀ > ♂	Physical	H = non-H; Non-H ♀ = ♂
Psychological	♀ = ♂	Psychological	(0|1) ♀ < ♂	Psychological	(0|1) ♀ = ♂	Psychological	(0|1) Non-H ♀ = ♂
Sexual	♀		(> 1) ♀ = ♂		(> 1) ♀ = ♂		(> 1) Non-H ♀ > ♂
Psychological IPV ~		Physical IPV ~		Physical IPV ~		Sexual IPV ~	
↓ General health	♀	↓ Mental health	♀	= Mental health		↓ Mental health	Non-H ♀ < ♂
↑ Daily stress level	♀						
↑ Sleeping problems	♀ = ♂	Psychological IPV ~		Psychological IPV ~		Psychological IPV ~	
↑ Anxiety/depression	♀ = ♂	↓ Mental health	♀ > ♂	= Mental health		↓ Mental health	Non-H ♀ = ♂
		Physical IPV ~		Physical IPV ~		Not assessed	
		↓ Relationship satisfaction	♀ > ♂	↓ Relationship satisfaction	♀		
		↑ Attachment avoidance	♀ = ♂	↑ Attachment avoidance	♀		
		↑ Attachment anxiety	♀	↑ Attachment anxiety	♂		
Psychological IPV ~		Psychological IPV ~		Psychological IPV ~			
↓Relationship satisfaction	♀ = ♂	↓ Relationship satisfaction	♀ > ♂	↓ Relationship satisfaction	♀ = ♂		
		↑ Attachment avoidance	♀ > ♂	↑ Attachment avoidance	♀		
		↑ Attachment anxiety	♀ > ♂	= Attachment anxiety			
Not assessed		Physical IPV ~		Physical IPV ~			
		↓ Sexual satisfaction	♀ = ♂	↓Sexual satisfaction	♀		
		↑ Sexual dysfunction	♀ = ♂	↑Sexual dysfunction	♀ = ♂		
		↓ Sexual communication	♀	= Sexual communication			
		Psychological IPV ~		Psychological IPV ~		Psychological IPV ~	
		↓ Sexual satisfaction	♀ = ♂	↓ Sexual satisfaction	♀	↓ Sexual satisfaction	Non-H ♀ = ♂
		↑ Sexual dysfunction	♀ = ♂	↑ Sexual dysfunction	♀ = ♂	↑ Sexual dysfunction	Non-H ♀ = ♂
		↓ Sexual communication	♀ = ♂	↓ Sexual communication	♀		

PREVALENCE OF IPV

Overview of the Main Findings on the Prevalence of IPV

A primary theme within this doctoral dissertation is the description of the prevalence of IPV victimization within specific samples. *Chapter 2* started from the observation that the latest prevalence rates of violence at the hands of an intimate partner in Belgium date from 1998 (Bruynooghe, Nolanders, & Opdebeeck, 1998). By examining – in a nationally representative population-based sample – the extent to which 1472 adult Belgian women and men experienced IPV by their current partner in the past 12 months, we aimed at providing up-to-date national IPV prevalence estimates. The following conclusions could be drawn: The annual prevalence of physical IPV in a current relationship was 1.3% and no differences were noted between women and men. Fourteen percent of the respondents experienced psychological violence, and no gender differences were found. Only women (0.3%) reported sexual intimate violence. With regard to sociodemographic risk factors that have repeatedly been shown to be associated with IPV victimization[2] (Stith, Smith, Penn, Ward, & Tritt, 2004), this study revealed that respondents who experienced psychological IPV in the past 12 months were more likely to be currently single or divorced, and perceived their social contacts with family and friends as less sufficient.

In *Chapters 3* through *5,* we aimed to further the research on lifetime IPV prevalence estimates and gender differences in IPV victimization within specific populations. All studies used the same IPV measures. As explained in detail within the different chapters, we used count models that assessed the effects of our predictors (e.g., gender, sexual orientation, and sociodemographic risk markers) with respect to the

[2]We only examined the link between sociodemographic risk factors and psychological IPV due to the low numbers of respondents reporting physical and sexual IPV.

chance of experiencing IPV on the one hand, and with respect to the frequency of the experienced intimate violence on the other hand. *Chapter 3* describes IPV prevalence estimates among 1448 heterosexual women and men in Flanders. Lifetime experiences of physical violence were reported by 10.0% of the respondents, while 56.7% reported at least one incidence of psychological violence. The chance to experience lifetime psychological IPV was slightly higher among men compared to women. However, among the victims, heterosexual women and men reported on average the same frequencies of physical and psychological violence. The chance to experience psychological IPV slightly decreased as respondents grew older and increased with a higher education level. Furthermore, higher levels of lifetime IPV were reported by people who perceived their family income as insufficient (physical and psychological IPV) and those who mentioned lower levels of social support (physical and psychological IPV). Lower levels of lifetime IPV were reported by those who are currently in a romantic relationship (psychological IPV), and those with a higher education level (psychological IPV).

In *Chapter 4* we aimed to explore the prevalence of IPV in a representative population-based sample of Turkish ethnic minority women and men in Flanders[3] (*N* = 392). Lifetime prevalence estimates for IPV showed that 14.3% of the Turkish respondents have experienced physical violence and 66.0% of the Turkish respondents have experienced psychological violence at some point at the hands of an intimate partner. Turkish women were more likely to have experienced physical violence compared to Turkish men. With regard to psychological violence, no gender differences were found indicating that Turkish women and men were equally likely to experience lifetime psychological violence. Lower reports of lifetime IPV were reported by Turkish respondents who are currently in a romantic relationship (physical and psychological IPV), those with a higher education level (physical IPV), and by those with a good social

[3] We refer to respondents with at least one parent with Turkish nationality (i.e., born in Turkey).

support network (psychological IPV). The chance of being psychologically victimized decreased with growing older, and increased with the importance a respondent attached to religion.

Chapter 5 specifically focused on IPV among a non-heterosexual population. Two large-scale community samples were used (a) to estimate the prevalence of lifetime IPV among non-heterosexuals, and compare these prevalence estimates to a heterosexual population in Flanders (Sample I; *N* = 119 non-heterosexuals and 1571 heterosexuals), and (b) to explore gender differences in lifetime IPV victimization rates among a specific population of non-heterosexuals (Sample II; *N* = 2401 non-heterosexuals). Results from the first representative population-based sample (i.e., Sample I) revealed that lifetime physical violence inflicted by an intimate partner was reported by 14.5% of the non-heterosexuals. Lifetime psychological violence was reported by 57.9% of the non-heterosexuals. Furthermore, our findings indicate that non-heterosexuals were as likely as heterosexuals to report both forms of intimate violence. Based on the second community sample (i.e., Sample II), we found that non-heterosexual women were as likely as non-heterosexual men to experience lifetime physical, sexual and psychological violence. However, non-heterosexual female victims reported higher frequencies of lifetime psychological victimization compared to their male counterparts. Furthermore – based on Sample II – this study demonstrated that lower frequencies of lifetime IPV were related to a higher education level (psychological, physical and sexual IPV) and currently being in a romantic relationship (psychological and sexual). Slightly higher frequencies of psychological violence were reported by older respondents.

A Summarizing View on the Prevalence of IPV

In the following paragraphs we discuss what we can conclude about (a) the prevalence of IPV, (b) IPV among minority populations, (c) gender differences in IPV victimization and (d) risk markers for IPV victimization based on the aforementioned findings.[4]

Prevalence of IPV. A consistent finding obtained in Chapters 3 through 5 is that our lifetime IPV prevalence estimates uncover low to moderate counts of physical and psychological violence. The average score for physical IPV victimization (Range: 0-4) varied from .14 (*SD* = .46) among heterosexuals, over .23 (*SD* = .63) among non-heterosexuals, to .24 (*SD* = .69) among Turkish ethnic minorities. In a similar vein, estimates of psychological violence (Range: 0-28) fluctuated from 2.69 (*SD* = 4.07) among heterosexuals, over 2.77 (*SD* = 4.31) among Turkish ethnic minorities, to 3.16 (*SD* = 4.29) among non-heterosexuals. These low frequencies are totally in line with our expectations. As described in the introductory chapter of this dissertation, the use of population-based samples implies that we did not examine the most severe forms of intimate violence (i.e., intimate terrorism) and suggests that we have mainly measured common couple violence (Johnson, 1995; Johnson & Ferraro, 2000). As hypothesized, people who experienced physical violence were also more likely to report psychological violence (Chapters 2 through 5). In addition, psychological violence was in each study far more prevalent than both physical (Chapters 2 through 5) and sexual violence (Chapter 2).

Our findings on the annual prevalence rates of violence within intimate relationships are largely in line with previous studies conducted in community samples

[4]It is important to note is that Chapter 2 adopted a different reference period than Chapters 3 through 5 (i.e., annual IPV vs. lifetime IPV). Additionally, Chapter 2 used items adopted from the French national survey on violence against women (ENVEFF; Jaspard et al., 2002) while our subsequent studies used items adapted from the WHO multi-country study on women's health and domestic violence against women (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005) and from the Conflict Tactics Scale (Strauss, 1979). This method variance restricts the comparability of the prevalence estimates between our first and later empirical studies.

(Breiding, Black, & Ryan, 2008; Jaspard et al., 2002). Likewise, our results on lifetime physical violence lie in the 10% to 32% range found in European research[5] on physical IPV against women (Hagemann-White, 2001; Muller & Schröttle, 2004). Noteworthy is that our estimates for physical IPV – varying from 10.0% in Chapter 3 to 14.5% in Chapter 5, are at the lower end of this European range. This is possibly due to method variations and the use of representative population-based samples. It has namely been argued that prevalence estimates of IPV are lower in representative compared to community samples (Nielsen & Einarsen, 2008). In sum, regardless of the low frequencies our results suggest that both physical and psychological violence are common phenomena within intimate relationships in Flanders.

IPV among minority populations. The notion that IPV is more prevalent among our Turkish *ethnic minority population* compared to the majority population in Flanders received partial support. Consistent with previous research (e.g., Field & Caetano, 2004; Rizo & Macy, 2011; Taft, Bryant-Davis, Woodward, Tilman, & Torres, 2009), significantly higher estimates were obtained among the Turkish ethnic minority group compared to the majority group for both physical (14.3% vs. 10.0%; $p < .01$) and psychological IPV (66.0% vs. 56.7%; $p < .001$; Chapters 3-4). An important comment, however, should be added to these findings. According to the structural inequality theory, elucidated in our introductory chapter, significant differences between both groups decline and even dissolve when controlling for a number of sociodemographic characteristics (e.g., Field & Caetano, 2004). Consequently, strictly based on differences in prevalence estimates we cannot conclude that IPV is more prevalent among people from Turkish origin compared to Flemish people. A more reliable comparison could be made between heterosexuals and *non-heterosexuals*. Indeed, controlling for sociodemographics we found that

[5] No European comparison is made regarding lifetime prevalence estimates for psychological violence. This is due to the fact that only limited empirical studies include psychological IPV prevalence estimates (Krahé, Bieneck, & Möller, 2005). Consequently, to our knowledge, no compelling international (Krahé et al., 2005) and European (Hagemann-White, 2001) reviews discuss prevalence ranges for psychological violence.

physical and psychological IPV were equally prevalent among heterosexuals and non-heterosexuals. These findings are in line with existing literature (e.g., Alexander, 2002; Murray & Mobley, 2009). Generally speaking, our findings suggest that IPV is at least as prevalent among people from Turkish origin and among non-heterosexuals in Flanders as among Flemish heterosexual people. This illustrates the relevance of providing equal theoretical and research attention to IPV among minority populations as to IPV among majority populations.

Gender differences in IPV victimization. In general, our hypotheses on gender differences in IPV victimization were largely supported. In line with the literature on common couple violence (Archer, 2000; Strauss, 2009), heterosexual women and men were about as likely to report physical and psychological IPV victimization (Chapter 2 -3). Consistent with the literature on IPV among ethnic minorities (Archer, 2006), Turkish women were more vulnerable for physical victimization than Turkish men. No gender difference was found regarding psychological violence. Lastly, our findings suggested that non-heterosexual women and men were as likely to report physical and psychological IPV. Yet, non-heterosexual women reported higher frequencies of psychological violence. In general, we can conclude that the above described results closely connect to the existing literature on gender differences. Additionally, they extend the literature regarding gender differences among non-heterosexuals. As Turkish women experienced higher rates of physical IPV than men, the question can be raised whether the same relational dynamics are at play in the different investigated populations (i.e., heterosexuals and non-heterosexuals vs. Turkish ethnic minorities). For instance, it is possible that the physical violence experienced by women from Turkish origin is a manifestation of a patriarchal culture where men try to dominate their partner. Or, it is likely that these Turkish women are less empowered, which makes them more vulnerable to experiencing intimate violence (Archer, 2006). In order to explore these relational dynamics more in depth, future research needs to identify the

motives behind these violent acts. Unfortunately, this could not be examined with our data.

Risk markers for IPV victimization. In line with Stith and colleagues' meta-analysis (2004) on risk markers for IPV victimization, we consistently found that both having a romantic relationship and a good social support network were associated with lower levels of past IPV victimization (Chapters 2 through 5). Except for Chapter 2, all chapters revealed that persons having a lower education level experienced more IPV. Inconsistent results were found for age. Whereas some studies report that an increase in age corresponded with a decrease in victimization (Chapters 3 & 4), others found no or small inverse results (Chapters 2 & 5). Religion only mattered among the Turkish ethnic minority group (Chapter 4). In short, these findings confirm the importance of multifactorial models to explain IPV victimization (Bartholomew & Cobb, 2011; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002; Stith et al., 2004).

RELATIONAL DYNAMICS

A second theme of this doctoral dissertation focused on how the experience of intimate violence is related to (a) victims' mental well-being as well as (b) their relational and sexual well-being within an intimate relationship. To this end, Chapters 2 to 5 included a range of individual and relational correlates. In the following paragraphs we will discuss the observed associations between IPV and victims' well-being in each chapter.

Overview of the Main Findings on IPV Victims' Well-Being

Chapter 2 investigated how psychological IPV victimization within the past 12 months is related to different aspects of victims' mental well-being. In general, persons who experienced psychological victimization were more likely to report sleeping

problems, feelings of depression or anxiety, a poorer general health, and more daily stress (see Table 1). The latter two health correlates only applied to victimized women. Additionally, we aimed to forward population-based research on the link between common couple violence and relationship satisfaction. Higher levels of psychological violence corresponded with a decrease in relationship satisfaction among both women and men. To conclude, these findings confirmed our hypotheses that IPV victimization is related to a decline in mental and relational well-being. However, as psychological victimization only accounted for 3% (i.e., depression or anxiety) to 11% (i.e., relationship satisfaction) of the variance in victims' individual and relational well-being, these results need to be validated with further population-based research.

Chapter 3 extends the previous chapter in several ways. First, this chapter examined how both lifetime physical and psychological IPV were related to victims' well-being. Second, a wide range of relational correlates was included to determine victims' current well-being in an intimate partner relationship. Based on theoretical and/or empirical evidence, we supposed that higher levels of physical and psychological victimization would be associated with lower levels of mental health and with a decline in relational (i.e., a decrease in relationship satisfaction and an increase of insecure attachment orientations) and sexual well-being (i.e., a decrease in sexual satisfaction and sexual communication and an increase of sexual dysfunction). Furthermore, we expected that gender would moderate the above associations between IPV victimization and well-being. Our results showed that lifetime physical IPV victimization is related to decreased levels of relationship satisfaction and sexual satisfaction, and to increased levels of avoidant attachment orientations and sexual dysfunction in both women and men (see Table 1). A gender difference was noted for relationship satisfaction indicating a more adverse outcome for women than for men. Lastly, only women reported a decrease in mental health and sexual communication and an increase of attachment anxiety. Lifetime psychological victimization was related to decreased levels of mental

health, relationship satisfaction and sexual satisfaction, and corresponded with more difficulties with sexual communication. Furthermore, it was related to increased insecure attachment orientations and sexual dysfunction. These adverse mental, relational and sexual correlates of psychological IPV were present in both women and men but except for the latter correlates, the effects were more pronounced for women than for men.

Building further on the previous chapter, *Chapter 4* explored how lifetime IPV victimization was related to Turkish ethnic minority victims' current well-being. The same analyses were carried out as in Chapter 3. Cultural-related differences in thoughts, cognitions and emotions might influence how IPV is related to the ethnic minority victims' well-being. However, based on logical reasoning and the empirical findings of Chapter 3 we expected to find similar results as in the previous chapter. However, IPV victimization was unexpectedly found to be unrelated to both Turkish women's and men's mental health (for both physical and psychological IPV) and their pattern of sexual communication (for physical IPV; for an overview see Table 1). In contrast, elevated levels of physical IPV were associated with less relationship satisfaction (women) and sexual satisfaction (women), and more attachment avoidance (women), attachment anxiety (men) and sexual dysfunction (women and men). Whereas both psychologically victimized women and men reported less relationship satisfaction and more sexual dysfunction, only women reported more attachment avoidance and less sexual communication and sexual satisfaction. In sum, lifetime IPV did not appear to affect Turkish victims' current mental health. Yet, IPV victimization was, mainly among women and to a lesser extent among men, related to adverse relational and sexual correlates in intimate relationships. Later in this general discussion we will discuss possible explanations for the absence of an effect on victims' mental health.

In our final chapter, *Chapter 5*, we aimed at furthering the research on non-heterosexual IPV victims' mental and sexual well-being (by means of Sample II, see

above). We expected that higher scores of IPV (i.e., physical, sexual, and psychological) would correspond with lower levels of mental health and sexual satisfaction and with increased levels of sexual dysfunction. Furthermore, we hypothesized that the associations would be stronger for non-heterosexual women than men. Decreased levels of mental health were reported by non-heterosexuals reporting higher levels of psychological (in women and men) and sexual (in men) IPV. Furthermore, psychological IPV was related to a decrease in sexual satisfaction, and an increase of sexual dysfunction in both women and men[6]. In short, both non-heterosexual women and men reported a decline in mental and sexual well-being when having experienced psychological violence and non-heterosexual men reported a decrease in mental health when having experienced lifetime sexual IPV.

A Summarizing View on and Theoretical Implications for IPV Victims' Well-Being

Based on the results described above, we will in the following summarizing view outline our observed associations between IPV and victims' mental well-being and relational and sexual well-being (i.e., relational correlates). In addition, we will discuss some theoretical implications of our research findings.

Mental well-being. Elevated levels of physical and psychological IPV victimization corresponded with a decreased mental health (Chapters 2, 3 & 5; see Table 1). One remarkable exception was noted among persons with a Turkish background. Neither physical, nor psychological IPV victimization was related to a diminished mental health (Chapter 4). Possible explanations for this lack of effect on mental health could be the

[6]A comment should be made to these results described above. Different from Chapter 3 and Chapter 4, no separate analyses were conducted for the effects of lifetime physical, sexual and psychological violence on victims' well-being within this chapter. As no effect was found for physical victimization, one could mistakenly conclude that physical IPV victimization is unrelated to non-heterosexuals' mental and sexual well-being. Post-hoc analyses were carried out to examine the individual effects of physical violence and revealed a negative association with victims' well-being. Yet, when controlling for the different types of victimization, only psychological violence remained significantly significant. This is an important contribution in and on itself.

nature of the health outcome (Keyes & Ryff, 2003) or cultural differences regarding the shape, expression and intensity of individual emotions (Markus & Kitayama, 1991; Kitayama, Park, Sevincer, Karasawa, & Uskul, 2009). Conforming the literature (see Caldwell, Swan, & Woodbrown, 2012), the present dissertation also found mixed results regarding gender differences: In some studies women were more likely to suffer from mental health difficulties than men (Chapters 2 & 3), while in our non-heterosexual study women and men were reporting a similar decline in mental health (Chapter 5). Moreover, the non-heterosexual men in this study reported a poorer mental health compared to women in response to sexual IPV. In short, our data confirm the considerable evidence on the association between physical IPV and mental well-being (e.g., Campbell, 2002; Zlotnick, Johnson, & Kohn, 2006) and expand the literature on the association between psychological IPV and mental well-being (Follingstad, 2009). Continued investigation of IPV victims' mental well-being is recommended in order to (a) clarify the inconsistent findings about gender differences and (b) explore whether the absence of an effect among our Turkish respondents can be replicated in future population-based research.

Relational correlates. In general, the experience of physical or psychological IPV was related to a decrease in *relationship satisfaction* in Flemish and Turkish victims' current intimate relationship (Chapters 2 to 4). Moreover, our results suggest that physical IPV victimization is more harmful for women's than for men's relationship satisfaction (see Table 1). A more complex relationship with gender is found regarding the association between psychological IPV and relationship satisfaction: Chapter 3 confirms the typical pattern of stronger associations for women than for men, while Chapters 2 and 4 revealed that women and men reported a similar decline in relationship satisfaction when having experienced psychological IPV. Different theoretical conclusions can be drawn from our findings. First, our results suggest that a history of even low to moderate common couple violence is associated with a decline in victims' current relationship satisfaction. Until now, empirical evidence on this link

predominantly relied on clinical samples reporting higher levels of severe aggression (Godbout, Dutton, Lussier, & Sabourin, 2009; Johnson, 2008). Second, IPV victimization corresponded with a decline in relationship satisfaction regardless of respondents' ethnical background. Thus, it seems important that the relationship satisfaction of ethnic minority victims receives further recognition (Katz, Kuffel, & Coblentz, 2002). Third, to the best of our knowledge only two non-clinical studies examined the moderating role of gender in the association between physical IPV and relationship satisfaction (Katz et al., 2002; Williams & Frieze, 2005). Our work confirms the findings of these studies. Lastly, our data contribute to the empirical knowledge on how psychological IPV is related to women's and men's relationship satisfaction because to date, most literature on this topic is only anecdotal (Follingstad, Rogers, & Duvall, 2012).

Higher levels of physical as well as psychological violence consistently corresponded with elevations in *avoidant attachment* orientations and often with elevations in *anxiety attachment* orientations as well (Chapters 3 & 4). As far as we know, only one non-clinical study has reported on gender-related differences in the association between IPV and attachment (Henderson, Bartholomew, Trinke, & Kwong, 2005). In contrast to Henderson and colleagues (2005), we found evidence for a moderating role of gender: Regarding attachment avoidance, the results were more pronounced for women than for men (Chapters 3 & 4). Less clear associations were found regarding gender and attachment anxiety. For instance, Chapter 3 reports stronger associations for women than for men and Chapter 4 only revealed an effect for Turkish men. The meaning of these gender differences needs further investigation. Despite this latter caveat, our research indicates that victims of common couple violence suffer from attachment insecurities. To date, studies examining this link in non-clinical samples remain relatively few in number (Mikulincer & Shaver, 2007). To conclude, our findings imply that attachment theory is, apart from a useful framework for understanding IPV perpetration, an interesting framework to adopt when studying IPV victimization.

Compared to the above described relational correlates of IPV, victims' sexual well-being within an intimate relationship has received the least empirical attention. In Chapters 3 through 5, we therefore devoted considerable attention to the association between the experience of IPV and victims' *sexual satisfaction* and *sexual functioning*. Consistent conclusions could be drawn from these studies. Indeed, persons who reported higher levels of both lifetime physical and psychological intimate violence were less sexually satisfied within their current intimate relationship. Also, higher levels of IPV victimization tended to co-occur with more sexual dysfunction. Furthermore, based on sex research within intimate relationships (e.g., Birnbaum, Reis, Mikulincer, Gillath, & Opraz, 2006; Stephenson & Meston, 2010), we expected IPV victimization to be stronger related to women's than to men's sexual well-being. In spite of these assumptions, neither for sexual satisfaction (Chapters 3 and 5), nor for sexual dysfunction (Chapters 3 to 5) gender differences were observed. In sum, the findings raised by this dissertation demonstrate that IPV victimization negatively affects victims' sexual well-being in an intimate relationship, which to the best of our knowledge has rarely been studied to date. Consequently, these findings highlight the need for a more complete, theoretical and empirical understanding of sexual satisfaction and sexual dysfunction for women and men with a history of IPV.

Finally, except for Turkish victims of physical intimate violence (Chapter 4), elevated levels of physical and psychological IPV correlated with decreased levels of *sexual communication*. Further, these associations pertained mainly to women (Chapters 3 & 4), which is consistent to the literature that women are in general more likely to disclose their sexual likes and dislikes compared to men (Byers & Demmons, 1999). Hence, it is likely that a history of IPV affects their willingness to be vulnerable about their sexual needs and whishes more. Our results on the association between IPV and sexual communication provide support for (parts of) the intimacy process model of Reis & Shaver (1988).

To conclude, our different studies show that both lifetime physical and psychological common couple violence are negatively related to victims' current mental as well as their relational and sexual well-being in an intimate partner relationship. Furthermore, our findings applied – although not always to the same extent – to both women and men, to heterosexual and non-heterosexual people and to people from Turkish origin in Flanders. Several theoretical implications can be drawn from these findings. A *first* implication refers to the need of an integrative theoretical framework to approach IPV victims' well-being from a multidimensional perspective. To date, the most widely known integrative framework within the IPV research field is the ecological model of Heise and Garcia-Moreno (2002). This model explains IPV victimization by describing risk markers at multiple levels (i.e., individual level of the victim/perpetrator, the relationship, the community and societal level). Unfortunately, the model is lacking an integrative approach that accounts for outcome variables at multiple levels (i.e., on individual, relationship, community and societal level). In our opinion, further theoretical development should account for the complex overlap between factors that may operate as risk markers and as outcomes of IPV. Our work specifically focused on victims' well-being at the relationship level. Based on our results, we stress that the experience of lifetime IPV makes people vulnerable in their intimate relationships.

A *second* implication involves the presence of minority populations in IPV research. Compared to our majority samples, some remarkable results were observed in our ethnic and sexual minority samples. For instance, gender seems to play a different role and some different or contrasting associations were found between IPV victimization and well-being. These findings highlight the need to put these underexposed populations more consequently on the research agenda.

A *third* implication concerns psychological IPV. Based on our above described results, it seems relevant to consider psychological IPV as a form of violence in itself. For instance, all studies revealed that the experience of psychological violence corresponded

with a decline in mental, relational, and sexual well-being. Moreover, our non-heterosexual study revealed that psychological IPV explains the largest amount of variance in victims' well-being even if they also experienced physical or sexual IPV.

A *final* implication refers to the aspect of gender in the IPV literature. The examination of a broader range of health correlates provides a more detailed view on how the experience of IPV affects women and men differently (Williams & Frieze, 2005). For instance, our data suggest that IPV victimization is in general more harmful for the mental and relational well-being of women than men. However, in terms of victims' sexual well-being no gender differences were noted. Future quantitative and qualitative research is recommended to explore the inconsistencies that characterize the literature more in-depth.

METHODOLOGICAL, POLICY, AND CLINICAL IMPLICATIONS

In the following paragraphs, we outline some methodological, policy and clinical implications of our dissertation. First, we discuss several methodological strengths and weaknesses of our studies.

Methodological Implications

Sample issues. A unique characteristic of our dissertation is the use of different representative population-based samples. This can be considered as a notable strength regarding our two major research goals. First, we discuss the strengths of this design with regard to our prevalence estimates. By relying on representative population-based samples of the Belgian population (Chapter 2) and Flemish population (Chapter 3), we increased the external validity of our prevalence findings (Murray & Mobley, 2009). Additionally, the use of a representative population-based sample of people from Turkish origin in Flanders led to reliable prevalence estimates of IPV among this specific

group (Chapter 4). To date, no official data were available in Belgium for IPV among a Turkish ethnic minority group. With regard to IPV among non-heterosexuals, we used a population-based sample to strive for a representative subsample of non-heterosexuals in Flanders (Chapter 5). As the numbers of non-heterosexuals in this population-based sample were small, an overrepresentation of non-heterosexuals in a second large-scale convenience sample allowed us to further explore this population. With regard to our second major goal, the use of these samples favored the generalizability of our findings on victims' well-being in response to common couple violence. That is, our work provides trustworthy evidence that the experience of low to mild forms of violence negatively affect victims' individual and relational well-being, regardless of victims' ethnical background or sexual orientation.

However, there are also some limitations that need to be addressed. First, it is highly likely that our different studies have been unable to fully expose "the dark number" of physical and psychological IPV. Estimates from general population–based samples often *under*estimate the extent of IPV in the overall population (Anderson, 2002; Johnson, 1995; Krahé et al., 2005). This is because some people affected by intimate violence will not take part in such surveys (i.e., selection bias). Also, some people will give no reply indicating IPV experienced (e.g., out of fear or shame or due to the sampling method). Consequently, the presented prevalence estimates reported throughout this dissertation should rather be seen as minimum estimates. That is, true IPV prevalence rates will probably be higher. Second, the different studies within this dissertation are completely based on self-reports. The respondents in these studies reported their own experiences with intimate violence and their own perceptions of their mental, relational and sexual well-being. We cannot be sure whether these self-reports would match with more objective behavioural measurements of these variables. Furthermore, we have to keep in mind that based on our studies, findings cannot be generalized to all IPV victims, they only apply to victims of low counts of IPV. Last,

population-based surveys have the enormous advantage to gather a wide variety of data among a great amount of people. However, this also implies that for timesaving reasons these surveys only include a limited number of validated questionnaires, and even often the shortened versions of these questionnaires. Consequently, these samples limit an in-depth exploration of the IPV phenomenon and its correlates. This was also the case in our study. Despite their theoretical relevance, some of the measures that we used proved to be weakly internal consistent. Namely, short versions of the Experience in Close Relationships Scale (ECR-S; Wei, Russell, Mallinckrodt, & Vogel, 2007) and the Dyadic Sexual Communication Scale (DSC; Catania, 1986) were used in Chapters 3 and 4. Although the first scale has been shown to be a reliable instrument to assess adult attachment (Wei et al., 2007), the internal consistency of the attachment anxiety scale was lower than expected in both chapters. We recommend that future research uses the full versions of these scales.

Different forms of IPV. A surplus value of our work is that we included psychological violence. Some remarks, however, are noteworthy regarding our measurement of psychological violence. The present dissertation classified persons as a victim of psychological violence if they experienced certain types of behaviour. Like most research, we did not examine whether these women and men felt or perceived themselves as psychologically abused. Nonetheless, how the aggression is perceived seems to impact victims' relationship satisfaction (Follingstad et al., 2012). Furthermore, all of our studies used the same measures for psychological violence. However, the conceptualization of psychological violence would benefit from a careful consideration of ethnical background and sexual orientation because these groups might be confronted with additional forms of psychological aggression (McHugh, Rakowski, & Swiderski, 2013). For instance, Turkish women might be prohibited to wear Western clothes and a well-known act of psychological IPV among non-heterosexuals concerns the threat of outing. A final remark refers to sexual IPV. As noted by Coker (2007),

sexual violence has often been approached from a separate research line as it may or may not occur in an intimate partner relationship. This was also the case in our dissertation. Although our surveys in Chapters 3 to 5 included the measurement of sexual violence, it was not specifically measured in the context of a romantic relationship. Consequently, sexual violence was not taken into account in most of our work. Future research would benefit from including sexual violence by an intimate partner.

Statistical analyses of IPV victimization. The scores on physical and psychological violence were not normally distributed in our studies. In order to handle the skewed distribution of IPV variables, scholars usually classify respondents in two or three categories. However, using categorical instead of continuous variables may result in different research findings (e.g., Doumas, Pearson, Elgin, & McKinley, 2008). As detailed within each chapter, the use of specific count models allowed us to examine the effect of gender, sexual orientation, and sociodemographic risk markers on the likelihood of experiencing IPV as well as on the frequency of lifetime IPV experiences among victims. We consider this a strength of the studies in this dissertation and in our opinion, these count models deserve to be more extensively used in future IPV studies.

Policy Implications

By providing statistical evidence of the extent of IPV in the overall population, researchers play a pivotal role in making this a social issue (Williams & Frieze, 2005). Influenced at least partially by the prevalence estimates provided in surveys such as ours, policy makers address this issue on societal or local level. In Belgium / Flanders, these include a wide range of interventions such as for instance the development of a national action plan (NAP) to combat IPV and other forms of domestic violence[7] within

[7] http://igvm-iefh.belgium.be/

each legislation, the stimulation of additional research to continuously improve our understanding of the phenomenon, the launch of a new website providing information for victims, perpetrators as well as professionals (www.partnergeweld.be; www.violenceentrepartenaires.be), and a free phone number "1712" one can call when having questions regarding (intimate partner) violence. We hope that the studies within the present dissertation both complement and extend the statistical based knowledge to inform policy makers regarding this important societal concern.

First, we have provided up-to-date prevalence estimates regarding different forms of annual and lifetime IPV victimization among heterosexual women and men in Belgium and Flanders. An important remark, however, should be made regarding the interpretation of these findings. Population-based research is a perfect tool to gather information on common couple violence. However, if policy makers aim to explore the need for financial resources that have to be extricated for victims and perpetrators of intimate terrorism, additional research is needed within a specific targeted population such as for instance women in shelters, and people in clinical and forensic settings. *Second*, the NAP of 2010 – 2014 to combat intimate violence indicates that special attention should be paid to immigrants as they are a vulnerable group for IPV victimization. We hope that our study on IPV among Flemish people from Turkish origin supports the need to focus on this population. Noteworthy is that our sample does not reflect the group of immigrants who only recently moved to Belgium. This is important because it is mainly this latter group that is considered as a high risk group in the NAP (due to their lack of knowledge about Belgium support services, language barriers, the risk of isolation and ignorance of support organizations). *Third*, our study on IPV among a non-heterosexual population clearly demonstrates that IPV has no sexual orientation boundaries and occurs in all intimate relationships. Yet, communication on IPV among non-heterosexuals at societal level is scarce. We believe that it is imperative that policy makers, the health care sector, the police, and the legal system are aware that IPV is not solely a heterosexual issue. Also, this awareness should be reflected in IPV campaigns.

Finally, a global recommendation for policy is formulated. In our opinion, population-based IPV research should be conducted on a more frequent basis (e.g., annually or every five year). Additionally, future surveys would benefit from the use of a standardized instrument to measure IPV. We strongly believe that this would help (a) to have a better view on short-term evolutions in IPV in the general population and (b) to evaluate the effectiveness of organized campaigns, actions and interventions more properly.

Clinical Implications

As has been demonstrated in this dissertation, abusive intimate relationships are related to significant mental health difficulties and decrease relational and sexual well-being in an intimate relationship. Although IPV has for a very long time been viewed as a strictly private matter, it is now viewed as a societal problem (Stith, Rosen, & McCollum, 2003). This shift in perspective has favoured changes in how IPV should be taken care of both at a legal and at a clinical level. At clinical level, it is important to acknowledge that different types of violence cannot be addressed in the same way. More specifically, it is definitely advised against that victims and perpetrators of intimate terrorism are involved in couple therapy because the risk of repeated violence is too high (Johnson, 2008). As the present dissertation mainly focused on common couple violence, our clinical implications refer to this group of victims and cannot be generalized to the context of intimate terrorism.

Relationship difficulties have been shown to be a leading reason why people or couples seek professional care (Bradbury & Karney, 2010; Stith et al., 2003). In this regard, clinicians should be aware that relationship problems cannot be treated effectively without giving consideration to the fact that the individual / couple in therapy has experienced intimate violence (Bradbury, Fincham, & Beach, 2000). However, even if IPV is no longer a private issue at societal level (at least in Western nations), people or couples in therapy will not spontaneously indicate that they experienced physical or

psychological violence in their current or former intimate relationship (Bradbury & Karney, 2010; Bradbury et al., 2000). Consequently, it is – in our opinion – the responsibility of a clinician to break this taboo. Given the prevalence rates of IPV in our and other population-based studies, a major clinical implication is that therapy should provide significant attention to clients' (individuals or couples) current conflict management skills as well as to conflict management patterns within a previous intimate relationship. We believe this is important because one or both partners' may be reacting to interactions in their current relationship from past experiences in their current or former intimate relationships (Metz & Epstein, 2002). Or, put differently: Regardless of the presenting problem in therapy, an assessment for intimate violence should routinely be included. According to Stith et al. (2003), this includes both a written IPV assessment as well as detailed interview with one or both partners.

Second, based on our findings that IPV victimization is related to a decrease in the relational and sexual well-being of couples, we believe that couple therapy might help couples who are struggling with relationship difficulties due to a history of IPV. It should be noted, however, that the number of studies on the effectiveness of couple treatment in response to IPV is scarce. Yet, there is preliminary evidence that couple therapy is at least as effective as individual gender-specific treatment approaches (i.e., male perpetrator and female victim; Stith et al., 2003). Several theoretical models of couple therapy have been proposed and used to treat IPV. We assume that depending on whether the violence has taken place in the current or former intimate relationship, a different therapeutic approach is recommended. In case of current IPV, we believe that the Ackerman Institute Model (Goldner, Penn, Sheinberg, & Walker, 1990; Greenspun, 2000) is a meaningful framework to work with. This meta-systemic approach to treat IPV combines the feminist and family psychologist view in therapy. Accordingly, next to focusing on individual factors (e.g., a history of abuse) and power and control dynamics, this treatment provides sufficient attention to couples' relational dynamics (Stith et al., 2003). Furthermore, emotionally focused couple therapy (EFCT; Johnson, 1996, 2003)

has been shown to be an effective intervention in the treatment of interpersonal problems including violence by an intimate partner.

EFCT has its foundations in attachment theory. Given that we found elevated levels of insecure attachment among IPV victims, we believe that this therapy is highly suitable to address victims' current relationship difficulties from past IPV experiences. This therapeutic model explicitly recognizes the impact that violent relationship experiences can have on one's current relationship functioning via their effect on victims' internal working models of self and significant others (i.e., the intimate partner; Mikulincer & Shaver, 2007). Exploration of these past adverse relationship experiences helps victims become aware of how they construe attachment bonds with their current intimate partner. Additionally, the exploration of present distortions in attachment orientation helps victims to reflect on earlier intimate relationships. In this attachment-based approach to couple therapy, the main focus is on the updating and revision of attachment-related thoughts and beliefs (Johnson, 2003; Mikulincer & Shaver, 2007). There is empirical evidence that new positive relationship experiences with an intimate partner produce beneficial revisions of one's internal working models (Mikulincer & Shaver, 2007). Drawing from social learning theory, a more cognitive behavioural approach is used to reduce relationship difficulties. Specifically in the context of IPV, cognitive behavioural therapy (CBT) has mainly been used to bring about changes in how IPV perpetrators manage their behaviour. However, we believe that – in combination with other therapeutic tools – CBT is a meaningful therapy to explore couples' daily interaction patterns. The main focus of this treatment approach is the prescription of new rules of behaviour for partners in order to increase their relational well-being in terms of relationship satisfaction and communication patterns (Bradbury & Karney, 2010). In sum, different theoretical frameworks and corresponding perspectives on therapy may be used to influence couples' disturbed relational dynamics.

FUTURE RESEARCH

In this section, we want to formulate some suggestions for future research that might contribute to a more complete understanding of IPV victims' relational well-being.

Measuring Intimate Partner Violence

A first suggestion refers to the measurement of IPV. Given the increasing interest of scholars in the distinct types of violence at the hands of an intimate partner, we would like to stress the importance of optimizing the measures to estimate both common couple violence and intimate terrorism. As underscored by Johnson (2008), researchers need to ask the right questions to distinguish between these different types of violence. To date, studies that have included this kind of questions remain few in number. Unfortunately, this dissertation extended the large majority of research that did not include these questions. Yet, future population-based and clinical research would benefit from assessing the context in which the violence has taken place. With regard to intimate terrorism, the presence of control tactics should be examined. Regarding common couple violence, conflict management patterns should be questioned. Next to distinguishing between types of violence, future research should continue to explore psychological violence both at conceptual as well as empirical level in order to get a thorough, evidence-based and well-grounded understanding of this phenomenon (Follingstad, 2007; McHugh et al., 2013). Although listing and counting a range of specific behaviours is a practical approach to examine psychological violence, it seems not the most sufficient way to fully conceptualize this subjective and complex form of violence.

Longitudinal Research

A second suggestion pertains to the study design to explore how IPV affects victims' well-being. In this dissertation, we expected that lifetime experiences of

intimate violence would predict victims' current well-being. For instance, we examined to what extent the experience of intimate violence related to victims' attachment orientation towards their current partner. Based on theoretical and empirical evidence we hereby hypothesized that adverse relationship experiences with an important other might alter the attachment orientation by increasing insecure attachment orientations. However, due to the cross-sectional nature of our studies caution should be exercised when interpreting these results as they only prove to be correlations, no true causal conclusions can be made. To address the question of causality, an ideal research design would have to measure attachment orientation beforehand and then follow individuals from their first violent intimate relationship throughout subsequent intimate partner relationships (Henderson et al., 2005).

Dyadic Research

For a long time, researchers have been very skeptical to examine IPV from a dyadic viewpoint (Bartholomew & Cobb, 2011; Winstok, 2007). Given the lack of a clear theoretical distinction between different types of violence, this choice seemed logical. The examination of victim characteristics could lead to the fact that victims would to a certain extent be considered as "responsible" for the violence they experienced. We believe that under no circumstances, a victim can be seen as responsible. Consequently, IPV research has a long tradition of focusing on either the victim or the perpetrator. Currently, the research climate is changing and researchers start to agree that, in a context of violence in response to escalated relationship conflict, both partners can simultaneously be victim and perpetrator of intimate violence. Stated differently, researchers start to recognize the theoretical importance of interactional and dyadic relationship dynamics in explaining violence within intimate relationships. Just as relationship scholars frequently study both partners in an intimate relationship in order to grasp relational dynamics and outcomes, we believe that IPV researchers need to

include both partners to obtain a comprehensive view of common couple IPV (Bartholomew & Cobb, 2011; Marcus, 2012; Winstok, 2007).

Mediation Analyses

Our dissertation suggested that women and men with a history of IPV experience a decreased mental health, report less relationship satisfaction, sexual satisfaction, and sexual communication, and show more insecure attachment and sexual dysfunctions. However, far less is known about the specific factors that may impact these adverse relational correlates. Hence, we found ourselves at the stage where more investigation is needed into mediating or moderating factors. Identifying which factors contribute to an adverse mental, relational, or sexual well-being would provide very useful information (Weston, 2008). For instance, it would allow us to better interpret why some consequences of IPV are not commonly found in all victims (Follingstad, 2009). Furthermore, it would be interesting if future research investigates potential mediators of this gender-related difference in relational outcomes subsequent to violence by an intimate partner. Given that IPV is generally stronger related to the relational well-being of women than men, we speculate that these differences may account for the association between intimate violence and relational well-being among women (e.g., Katz et al., 2002).

GENERAL CONCLUSION

Disagreement and conflict are inevitable within intimate partner relationships. Unfortunately, a number of partners resort to violence when being confronted with situations that are perceived as incompatible with their personal goals and interests (Bradbury & Karney, 2010). In this doctoral dissertation we have presented several representative population-based studies that document on the prevalence of physical and psychological IPV in specific populations, including an ethnic minority population

and a sexual ethnic minority population. As expected, IPV is a global phenomenon without cultural or sexual orientation boundaries. Overall, a substantial group of heterosexual women and men, Turkish ethnic minority women and men, and non-heterosexual women and men were found to experience violence by an intimate partner at some point in their lives. The frequency of these behaviours tended to be low to moderate. Lifetime IPV victimization was found to be related to a decline in mental health and puts people at risk for intimate relationships characterized by decreased levels of relationship satisfaction, sexual satisfaction, sexual communication, and increased levels of insecure attachment and sexual dysfunction. Given that in an intimate relationship even minor forms of intimate violence harm victims' mental as well as relational and sexual well-being, we hope that the studies included in this doctoral dissertation will generate both more clinical and non-clinical research focusing on the relational correlates of IPV.

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INTIEM PARTNERGEWELD

Definitie

De Wereldgezondheidsorganisatie (WGO) omschrijft intiem partnergeweld (IPG) als "het geheel van gedragingen binnen een intieme relatie die een fysiek, seksueel of psychologisch nadeel of leed veroorzaken. Het omvat fysieke agressie, seksuele dwang, psychologisch geweld en controlerende gedragingen" (WGO, 2010, p.11). Deze definitie omvat geweld gepleegd door de huidige of een ex-partner. Verder kunnen (ex-) partners gehuwd zijn of samenwonend maar dit is geen vereiste. Bovendien hoeft deze intieme relatie geen seksuele relatie te omvatten. Deze vorm van geweld kan gericht zijn van mannen naar vrouwen toe, van vrouwen tegenover mannen en kan voorkomen in holebirelaties. Ten slotte wordt IPG beschouwd als een globaal fenomeen dat geen grenzen kent naar culturele of etnische achtergrond (Saltzman, Fanslow, McMahon, & Shelley, 1999).

Uit bovenstaande definitie kan men afleiden dat IPG gekenmerkt wordt door drie vormen van geweld namelijk fysiek, seksueel en psychologisch geweld. Dit betekent dat IPG een grote variëteit aan gedragingen omvat (Winstok, 2007). Gezien onderzoek heeft aangetoond dat deze verschillende vormen van partnergeweld (a) dikwijls samen voorkomen, (b) heel erg verschillen in uitingsvorm (e.g., psychologisch IPG vs. seksueel IPG) en (c) kunnen samen gaan met verschillende gezondheidscorrelaten (Fournier, Brassard, & Shaver, 2011; Woodin, Sotskova, & O'Leary, 2013) kunnen we besluiten dat IPG een complex en veelzijdig fenomeen is. Daarom worden onderzoekers aangewezen om in studies te differentiëren tussen de verschillende vormen van partnergeweld en niet alles onder de globale noemer 'IPG' te plaatsen (Fournier et al., 2011).

Intiem Terrorisme vs. Algemeen Koppelgeweld

Onderzoek naar geweld in intieme relaties werd gedurende lange tijd gedomineerd door twee tegenstrijdige stromingen (Johnson & Ferraro, 2000). De feministische stroming (e.g., Dobash & Dobash, 1979) ziet de oorzaak van partnergeweld in de overheersende patriarchale drang naar macht en controle van mannen over vrouwen. De "familie psychologie" stroming (e.g., Strauss & Gelles, 1990) daarentegen stelt dat partnergeweld het resultaat is van geëscaleerd conflict in intieme relaties. Johnson (1995) en Johnson en Ferraro (2000) probeerden de visies van beide stromingen te verzoenen door te stellen dat er niet één uniforme vorm van partnergeweld bestaat. Deze twee stromingen refereren naar twee types van geweld, namelijk "intiem terrorisme" en "algemeen koppelgeweld".

Intiem terrorisme. Wanneer men denkt aan geweld in een intieme partnerrelatie, dan denken meeste mensen aan intiem terrorisme. In het algemeen staat dit type van geweld bekend als de heteroseksuele man die ernstig fysiek en psychologisch geweld gebruikt ten opzichte van zijn vrouwelijke partner (Johnson & Ferraro, 2000). Dit type van geweld verwijst naar het systematisch gebruik van ernstig geweld om de partner te intimideren, controleren en onderwerpen. Dikwijls escaleert dit type van geweld over de tijd heen. Intiem terrorisme wordt het meest opgemerkt in klinische populaties en in forensisch onderzoek (Archer, 2000; Bradbury & Karney, 2010; Dobash & Dobash, 1979; Johnson, 2008; Johnson & Ferraro, 2000).

Algemeen koppelgeweld. Dit type van partnergeweld komt het vaakst voor. Een of beide partners stellen licht tot ernstig agressief gedrag. Echter, geen van beiden gebruikt geweld in functie van een continue nood aan macht en controle in de relatie. In tegendeel, algemeen koppelgeweld is dikwijls kortdurend en context-specifiek en wordt daarom ook "situationeel koppelgeweld" genoemd. Dit type van IPG komt voornamelijk voor in de context van onenigheid en gespannen conflictsituaties in de relatie. Ondanks het feit dat onenigheid en ruzie onvermijdelijk zijn in elke intieme

relatie, escaleren deze situaties bij sommige koppels tot geweld (Bradbury & Karney, 2010). Dit type van geweld weerspiegelt andere relatiedynamieken dan intiem terrorisme en wordt daarom veeleer opgemerkt in bevolkingsonderzoek dan in klinisch of forensisch onderzoek (Johnson, 2008; Johnson & Ferraro, 2000; Strauss, 2009). Gezien dit doctoraatsonderzoek rapporteert over verschillende (representatieve) bevolkingssteekproeven hebben wij voornamelijk algemeen koppelgeweld gemeten.

PREVALENTIE

Prevalentie van Intiem Partnergeweld

Internationaal onderzoek naar de prevalentie van IPG (i.e., of een persoon al dan niet ervaring heeft met IPG in een bepaalde tijdsperiode; Krahé, Bieneck, & Möller, 2005) heeft aangetoond dat tal van personen ooit in hun leven geconfronteerd worden met geweld gepleegd door een intieme partner. Bijvoorbeeld, Krahé en collega's (2005) rapporteren – op basis van 35 studies in 21 verschillende landen – dat 2.7% tot 52% van de vrouwen ooit te maken krijgt met fysiek partnergeweld. Een klein aantal van deze studies rapporteert cijfers voor mannen en daaruit blijkt dat 4.1% tot 19% van de mannen ooit het slachtoffer wordt van fysiek geweld. Omdat prevalentie cijfers zo uiteenlopend zijn – mede door methodevariaties – moeten ze steeds met voorzichtigheid geïnterpreteerd worden (Woodin et al., 2013).

Gezien prevalentie onderzoek zich lange tijd bijna uitsluitend toegespitst heeft op heteroseksuele vrouwen die het slachtoffer werden van fysiek geweld, is het belangrijk dat zowel het voorkomen van psychologisch geweld als intiem geweld gericht naar mannen verder geëxploreerd wordt in bevolkingsonderzoek.

Prevalentie van Intiem Partnergeweld bij Etnische en Seksuele Minderheden

Zoals blijkt uit de WGO definitie kent IPG geen grenzen naar culturele of etnische achtergrond, noch naar seksuele voorkeur (Saltzman et al., 1999). Sinds recent is er een toegenomen interesse in het begrijpen van IPG bij etnische en seksuele minderheden.

Etnische minderheden. De laatste decennia is er een enorme groei in het aantal etnische minderheden in Westerse landen (Tartakovsky & Mezhibovsky, 2012). Met deze veranderende populaties, is er ook een toenemend belang om etnische minderheden op te nemen in bevolkingsonderzoek naar partnergeweld. Algemeen wordt aangenomen dat etnische minderheden een risicogroep vormen voor IPG (Raj & Silverman, 2002). Zo heeft onderzoek bijvoorbeeld aangetoond dat vrouwen die tot een etnische minderheidsgroep behoren meer partnergeweld rapporteren dan vrouwen van een meerderheidsgroep (e.g., Rizo & Macy, 2011; Taft, Bryant-Davis, Woodward, Tillman, & Torres, 2009). Twee dominante theorieën pogen het verhoogd voorkomen van IPG bij etnische minderheidsgroepen te verklaren. Volgens de "subculture of violence theory" is partnergeweld in sommige collectivistische, patriarchale culturen tot op een bepaald niveau toegelaten om de machtsverschillen tussen mannen en vrouwen te benadrukken (Field & Caetano, 2004). De "structural inequality theory" daarentegen stelt dat het eerder de sociale structuren (e.g., laag opleidingsniveau, laag inkomen, sociale isolatie) zijn dan hun culturele achtergrond die etnische minderheden kwetsbaarder maken voor IPG (Field & Caetano, 2004). Hoogstwaarschijnlijk zijn beide theorieën complementair (Tartakovsky & Mezhibovsky, 2012).

Seksuele minderheden. Onderzoek naar IPG in holebirelaties is uitermate relevant om aan te tonen dat partnergeweld voorkomt buiten de traditionele man – vrouw relaties, zoals voorgeschreven door feministische aanhangers. Vanuit verschillende invalshoeken hebben onderzoekers geprobeerd om partnergeweld bij

niet-hetero's[1] te verklaren (zie Burke & Follingstad, 1999). Vanuit een hetero-normatieve invalshoek wordt gesteld dat IPG bij niet-hetero's minder voorkomt dan bij hetero's omdat zij niet geconfronteerd worden met traditionele man-vrouw machtsverhoudingen. Vanuit een holebi-specifieke invalshoek daarentegen wordt gesteld dat niet-hetero's net meer kans maken op IPG omdat zij met additionele minderheidsstressoren te kampen hebben die een extra druk leggen op hun relatie. Bestaand onderzoek toont aan dat IPG in deze groep minstens even vaak voorkomt als IPG in heteroseksuele relaties (Alexander, 2002; Murray & Mobley, 2009).

Ondanks de toegenomen interesse blijft systematisch onderzoek naar IPG in deze populaties tot op vandaag beperkt (Taft et al., 2009). Gezien bovengenoemde groepen verondersteld worden om meer, of tenminste in dezelfde mate geconfronteerd te worden met partnergeweld is verder onderzoek, gebaseerd op ecologische valide steekproeven noodzakelijk.

RELATIONELE DYNAMIEKEN

Onderzoek naar de *individuele* gezondheidscorrelaten van IPG heeft aangetoond dat het ervaren van geweld in een intieme relatie veelal samengaat met een minder goed mentaal, fysiek en seksueel welzijn van slachtoffers (e.g., Campbell, 2002; Coker, 2007). Ondanks deze interessante onderzoeksbevindingen, bleven een aantal andere gezondheidscorrelaten, zoals *relationele* correlaten van IPG dikwijls buiten het vizier van onderzoek (Bartholomew & Cobb, 2011; Lawrence & Bradbury, 2001).

De interpersoonlijke schema theorie (Baldwin, 1992; Cloitre & Rosenberg, 2006; Hien & Ruglass, 2009) biedt ons een interessant overkoepelend kader om het belang te benadrukken van onderzoek naar de relationele correlaten van IPG. Deze theorie stelt

[1] In lijn met Laumann en collega's (1994) conceptualiseert dit doctoraatsonderzoek seksuele voorkeur als een driedimensioneel construct (i.e., seksuele zelfidentificatie, seksueel gedrag en seksueel verlangen). Daarom verkiezen we de term 'niet-hetero' eerder dan lesbisch, homo, of biseksueel (LHB). Sommige personen worden geclassificeerd als niet-heteroseksueel ongeacht of ze zichzelf benoemen als LHB.

dat “een schema” ons interpersoonlijk functioneren in (intieme) relaties stuurt door middel van hun invloed op het verwerken van sociale informatie in interpersoonlijke relaties. Concreet stelt deze theorie dat mensen op zoek gaan naar interpersoonlijke relaties die hun relatieschema’s bevestigen en dat zij nieuwe informatie zullen bekijken en interpreteren in functie van eerdere relationele ervaringen. Vervolgens zullen zij zich ook in functie daarvan gedragen. Bijvoorbeeld, mensen met liefdevolle, positieve interpersoonlijke ervaringen hebben positieve relatieschema’s en zullen daardoor automatisch hun kans vergroten op positieve relaties in de toekomst. Daar tegenover staat dat mensen met negatieve relatie ervaringen een groter risico lopen om via het principe van “selffulfilling prophecy” hun negatieve relatieschema’s te bevestigen en te herhalen in latere interpersoonlijke relaties (Cloitre & Rosenberg, 2006; Hien & Ruglass, 2009). In dit doctoraatsonderzoek hebben we ons expliciet toegelegd op het onderzoeken van hoe ervaringen met partnergeweld gerelateerd zijn aan slachtoffers’ huidige relatietevredenheid, hechtingsoriëntatie ten opzichte van de huidige partner, seksuele tevredenheid in de huidige partnerrelatie, het voorkomen van seksuele disfuncties in de partnerrelatie en de mate waarin slachtoffers met hun huidige partner kunnen communiceren over hun seksuele wensen en noden.

Relationele Correlaten

Zowel de sociale leertheorie (zie Bradbury & Karney, 2010) als de hechtingstheorie (Bowlby, 1969/ 1982, 1973) zijn interessante theorieën om het verband na te gaan tussen IPG en slachtoffers’ cognitieve en emotionele responsen in (latere) intieme relaties. De sociale leertheorie stelt dat relatie uitkomsten bepaald worden door koppels’ positieve en negatieve interactiepatronen (Bradbury & Karney, 2010). Concreet betekent dit dat herhaaldelijke conflictueuze en gewelddadige interacties tussen partners een negatieve invloed hebben op hoe relaties beoordeeld worden en dus leiden tot meer relatieontevredenheid. Zowel klinisch (e.g., Godbout, Dutton, Lussier, &

Sabourin, 2009) als bevolkingsonderzoek (Williams & Frieze, 2005) heeft aangetoond dat IPG samengaat met minder relatietevredenheid. De hechtingstheorie gaat van het idee uit dat eerdere relatie ervaringen vertaald worden in mentale representaties en beïnvloeden hoe mensen denken over en omgaan met hechtingsfiguren (e.g., intieme partner). Gegeven het feit dat mensen heel wat interpersoonlijke relaties hebben met anderen, is het logisch te veronderstellen dat nieuwe relatie ervaringen de hechtingsoriëntatie beïnvloeden. Met andere woorden, ervaring met IPG kan bijdragen tot negatieve mentale representaties over zichzelf en anderen waardoor onveilige hechtingsoriëntaties getriggerd worden. Empirische evidentie is gevonden voor meer onveilige hechtingsoriëntaties bij IPG slachtoffers (e.g., Henderson, Bartholomew, Trinke, & Kwong, 2005).

Onderzoek naar het seksueel welzijn van IPG slachtoffers heeft zich voornamelijk toegespitst op het seksueel risicogedrag van IPG slachtoffers (Coker, 2007). Veel minder onderzocht is hoe ervaringen met IPG gerelateerd zijn aan slachtoffers' seksueel welzijn in een intieme partnerrelatie. Het lijkt echter logisch te veronderstellen relatieschema's zullen interageren met het seksueel functioneren in de partnerrelatie (Dewitte, 2012). Ervaring met IPG kan een invloed hebben op hoe slachtoffers hun seksuele emoties genereren, ervaren en uiten. Daarom lijkt het ons plausibel dat IPG samengaat met minder seksuele tevredenheid en seksuele communicatie en meer seksuele disfuncties.

DOELSTELLINGEN VAN HET DOCTORAATSONDERZOEK

De doelstelling van het huidige doctoraatsonderzoek was tweeledig. Ten *eerste* wilden we meer inzicht krijgen in het voorkomen van IPG – specifiek, algemeen koppelgeweld – in verschillende populaties aan de hand van enkele grootschalige representatieve bevolkingssteekproeven. In het bijzonder wilden we nagaan in welke mate heteroseksuele mannen en vrouwen (Hoofdstukken 2-3), mannen en vrouwen van

Turkse origine in Vlaanderen (Hoofdstuk 4), en niet-heteroseksuele mannen en vrouwen (Hoofdstuk 5) te maken krijgen met verschillende vormen van IPG. Naast het in kaart brengen van prevalentie cijfers voor bovengenoemde populaties werden enkele specifieke hypotheses getoetst. Ten eerste veronderstelden we dat personen van Turkse origine meer IPG zouden rapporteren dan de Vlaamse heteroseksuele groep. Verder verwachtten we dat IPG bij niet-hetero's minstens even vaak zou voorkomen als IPG bij hetero's. In lijn met de literatuur verwachtten we geen geslachtsverschillen te vinden in het ervaren van IPG in de heteroseksuele Vlaamse groep maar wel in de groep van Turkse origine. Geen hypothesen naar geslacht werden geformuleerd in de niet-heteroseksuele populatie. Ten *tweede* wilden we beter begrijpen hoe het ervaren van algemeen koppelgeweld gerelateerd is aan slachtoffers' huidig mentaal en relationeel welzijn in een intieme partnerrelatie. Specifiek verwachtten we dat meer IPG zou samengaan met een minder goede mentale gezondheid, minder relatietevredenheid, seksuele tevredenheid en seksuele communicatie, en meer onveilige hechting en seksuele disfuncties. We verwachtten sterkere verbanden voor vrouwen dan voor mannen.

EEN BEKNOPT OVERZICHT VAN DE BELANGRIJKSTE BEVINDINGEN

Prevalentie

Overzicht prevalentie cijfers. 1.3% van de Belgen werd het slachtoffer van fysiek geweld en 14% van de Belgen kreeg in *de afgelopen 12 maanden* te maken met psychologisch geweld door de huidige partner. Geen verschillen werden hierbij gevonden voor mannen en vrouwen. Enkel vrouwen (0.3%) werden geconfronteerd met seksueel geweld (Hoofdstuk 2). Deze cijfers liggen in de lijn van prevalentie cijfers in internationaal bevolkingsonderzoek (e.g., Jaspard et al., 2002; Breiding, Black, & Ryan,

2008). Ervaring met geweld *doorheen de levensloop* werd enkel bevraagd in Vlaanderen (Hoofdstukken 3 – 5). We vonden dat 10% van de Vlaamse hetero's ooit fysiek geweld meemaakte en dat 56.7% van hen ooit geconfronteerd werd met psychologisch geweld (Hoofdstuk 3). Kijken we specifiek naar het voorkomen van IPG bij personen van Turkse origine in Vlaanderen, dan zien we dat 14.3% van hen ooit fysiek geweld meemaakte en 66.0% van hen ooit psychologisch geweld ervoer door een intieme partner (Hoofdstuk 4). De resultaten van ons laatste empirische hoofdstuk (Hoofdstuk 5) toonden tenslotte aan dat 14.5% van de niet-hetero's ervaring had met fysiek geweld en dat 57.9% van hen ooit psychologisch geweld had meegemaakt. Wat kunnen we concluderen op basis van onze prevalentie cijfers? Een consistente bevinding, over onze verschillende hoofdstukken heen (Hoofdstuk 3 – 5), is dat het voornamelijk gaat om lichte tot milde vormen van fysiek en psychologisch IPG. Deze bevindingen liggen volledig in de lijn van onze verwachtingen. Zoals reeds beschreven staat bevolkingsonderzoek erom gekend om voornamelijk de lichte vormen van algemeen koppelgeweld te meten (Johnson, 1995; Johnson & Ferraro, 2000). Verder liggen onze prevalentie cijfers voor fysiek IPG in de 10% tot 32% range van Europees onderzoek dat uitgevoerd werd naar fysiek geweld gericht tegen vrouwen (Hagemann-White, 2001; Muller & Schröttle, 2004). Echter, onze cijfers (van 10.0% in Hoofdstuk 3 tot 14.5% in Hoofdstuk 5) liggen aan het lage eind van deze range. Dit kan mogelijks verklaard worden door methodevariaties (Nielsen & Einarsen, 2008; Woodin et al., 2013).

IPG bij etnische en seksuele minderheden. Onze hypothese dat IPG vaker voorkomt bij personen van Turkse origine in Vlaanderen wordt gedeeltelijk bevestigd. Consistent met eerder onderzoek (e.g., Field & Caetano, 2004; Rizo & Macy, 2011; Taft et al., 2009) vonden we significant hogere prevalentie cijfers voor zowel fysiek (14.3% vs. 10%, $p < .01$) als psychologisch geweld (66.0% vs. 56.7%) in de Turkse groep dan in de Vlaamse groep. Deze bevindingen moeten echter met voorzichtigheid geïnterpreteerd worden. Volgens de reeds beschreven "structural inequality theory" verkleinen of

verdwijnen deze significante verschillen tussen beide groepen wanneer men rekening houdt met socio-demografische factoren. Met andere woorden, op basis van deze resultaten kunnen we niet eenduidig concluderen dat IPG vaker voorkomt bij personen van Turkse origine vergeleken met een Vlaamse groep. Een meer betrouwbare vergelijking konden we maken tussen hetero's en niet-hetero's. Namelijk, rekening houdend met enkele sociodemografische factoren vonden we – in lijn met de literatuur (e.g., Alexander, 2002; Murray & Mobley, 2009) – dat hetero's en niet-hetero's evenveel kans maken om ooit geconfronteerd te worden met fysiek en psychologisch partnergeweld. Ter besluit, onze resultaten suggereren dat IPG minstens even vaak voorkomt bij personen van Turkse origine en bij niet-heteroseksuele personen in Vlaanderen als bij heteroseksuele personen in Vlaanderen. Dit benadrukt het belang om deze minderheidsgroepen mee op te nemen in toekomstig bevolkingsonderzoek naar IPG.

Geslachtsverschillen. Globaal gezien werden onze verwachtingen rond geslachtsverschillen bevestigd. In lijn met de literatuur rond algemeen koppelgeweld vonden we ook in deze studies geen verschil tussen heteroseksuele mannen en vrouwen in het ervaren van IPG (e.g., Archer, 2000; Strauss, 2009). Consistent met de onderzoeksliteratuur naar IPG bij etnische minderheidsgroepen (e.g., Archer, 2006; Field & Caetano, 2004) vonden we dat de Turkse vrouwen vaker fysiek IPG rapporteerden dan Turkse mannen. Voor psychologisch geweld vonden we geen verschil tussen Turkse mannen en vrouwen. Tenslotte suggereren onze resultaten dat niet-heteroseksuele vrouwen en mannen even vaak het slachtoffer worden van fysiek en psychologisch IPG. Echter, onder de slachtoffers rapporteerden vrouwen meer psychologisch IPG dan mannen. Algemeen kunnen we besluiten dat deze bevindingen nauw aansluiten bij de bestaande literatuur en de literatuur uitbreiden op het vlak van geslachtsverschillen bij niet-hetero's. Dat uitgesproken geslachtsverschillen werden gevonden voor fysiek IPG in de Turkse groep leidt ons tot de vraag of IPG bij Turkse minderheden dezelfde relatie

dynamieken weerspiegelt dan in de andere groepen. Om hier een gefundeerd antwoord op te formuleren is het noodzakelijk dat de motieven van het geweld in kaart gebracht worden. Helaas kon dit niet achterhaald worden met onze onderzoeksdata.

Relationele Dynamieken

Ten tweede had dit doctoraatsonderzoek als doel om bij te dragen tot een beter begrip over hoe het ervaren van algemeen koppelgeweld gerelateerd is aan slachtoffers' huidig mentaal en relationeel welzijn.

Mentaal welzijn. Zoals voorspeld gingen hogere scores op zowel fysiek als psychologisch geweld gepaard met een minder goed mentaal welzijn (Hoofdstukken 2, 3 & 5). Een opmerkelijk resultaat vonden we terug bij personen van Turkse origine. Noch fysiek, noch psychologisch geweld gingen gepaard met een verminderd mentaal welzijn. Dit gebrek aan effect kan mogelijks verklaard worden door culturele verschillen in het ontwikkelen, het uiten en de intensiteit van negatieve emoties (Markus & Kitayama, 1991; Kitayama, Park, Sevincer, Karasawa, & Uskul, 2009). Zoals in de literatuur reeds gerapporteerd werd (zie Caldwell, Swan, & Woodbrown, 2012) vonden wij in dit doctoraatsonderzoek eveneens inconsistente effecten voor geslacht. Kortom, onze data suggereren dat ondanks de uitgebreide onderzoeksaandacht die mentaal welzijn reeds kreeg in dit domein, verder onderzoek aangewezen is. Dit doctoraatsonderzoek draagt bij aan de kennis over de negatieve invloed van psychologisch IPG op slachtoffers' mentaal welzijn. Toekomstig onderzoek kan ophelderen waarom er inconsistente geslachtsverschillen gevonden werden en of het gebrek aan effect bij een etnische minderheidsgroep gerepliceerd wordt in andere bevolkingsonderzoeken.

Relationele correlaten. Zoals verwacht ging het ooit ervaren van fysiek partnergeweld gepaard met minder *relatietevredenheid* in de huidige partnerrelatie (Hoofdstukken 3 & 4). Bovendien suggereren onze resultaten dat fysiek IPG een grotere impact heeft op de relatietevredenheid van vrouwen dan van mannen. Echter, indien

het gaat om psychologisch geweld dan zijn deze geslachtsverschillen veel minder uitgesproken. Deze bevindingen benadrukken het belang van onderzoek naar de relationele correlaten van psychologisch geweld. De kennis hierover is tot op vandaag eerder anekdotisch dan empirisch (Follingstad, Rogers, & Duvall, 2012). Verder zijn deze resultaten van theoretisch belang omdat ze aantonen dat ook lichte vormen van IPG samengaan met minder relatietevredenheid. Tenslotte wijzen ze de aandacht op het feit dat de relatietevredenheid van Turkse IPG slachtoffers verdere onderzoeksaandacht verdient.

We voorspelden en vonden evidentie voor meer onveilige *hechting* bij slachtoffers van fysiek en psychologisch IPG (Hoofdstukken 3 & 4). Met betrekking tot vermijdende hechting waren de resultaten over het algemeen meer uitgesproken voor vrouwen dan voor mannen. De link tussen geslacht en angstige hechting is minder duidelijk. Theoretisch zijn deze resultaten van belang omdat ze suggereren dat de hechtingstheorie een heel waardevolle theorie is om op te nemen in onderzoek naar slachtoffers van IPG en niet alleen in klinisch daderonderzoek (zie Mikulincer & Shaver, 2007).

Tenslotte kunnen we uit onze resultaten afleiden dat het ervaren van zowel fysiek als psychologisch IPG samengaat met minder *seksuele tevredenheid*, meer *seksuele disfuncties* en met minder *seksuele communicatie*. Enkel met betrekking tot de laatste variabele bleek er een significant geslachtsverschil te zijn, IPG had een grotere impact op het seksueel communicatiegedrag van vrouwen dan dat van mannen. Theoretisch benadrukken deze bevindingen het belang om in toekomstig onderzoek meer aandacht te besteden aan het seksueel welzijn van slachtoffers in een intieme partnerrelatie.

Algemeen beschouwd, wat kunnen we besluiten op basis van bovenstaande resultaten? Ten eerste, ons onderzoek toont aan dat ervaringen met IPG niet alleen gerelateerd zijn aan slachtoffers' individueel welzijn, maar ook aan hun relationeel welzijn in een intieme relatie. Bijgevolg pleit ons onderzoek voor de ontwikkeling van een integratief theoretisch model om slachtoffers' welzijn te kaderen vanuit een multidimensioneel perspectief (i.e., welzijn op verschillende niveaus). Gezien het verminderd mentaal en relationeel welzijn van Turkse slachtoffers en niet-heteroseksuele slachtoffers, refereert een tweede theoretische implicatie naar het belang om minderheidsgroepen op te nemen in bevolkingsonderzoek. Een derde theoretische implicatie heeft betrekking op psychologisch geweld. De nadelige effecten van psychologisch geweld op het mentaal en relationeel welzijn wijzen op de relevantie om deze vorm van geweld als een op zichzelf staande vorm van geweld te beschouwen. Met andere woorden, om de resultaten die gevonden worden voor fysiek IPG niet louter te exploreren voor psychologisch geweld. Een laatste theoretische implicatie heeft betrekking op de rol van geslacht in de IPG literatuur. Het onderzoeken van meerdere vormen van welzijn geeft een meer gedetailleerde kijk geeft op hoe geslacht gerelateerd is aan IPG (Williams & Frieze, 2005). Toekomstig onderzoek is zinvol om gender inconsistenties verder te exploreren.

IMPLICATIES VAN DE ONDERZOEKSRESULTATEN

Methodologische Implicaties

Uniek aan dit doctoraatsonderzoek is het gebruik van verschillende representatieve bevolkingssteekproeven om een antwoord te bieden op onze verschillende onderzoeksvragen. Deze steekproeven verhogen de externe validiteit van onze prevalentieschattingen en laten ons toe om de resultaten inzake het welzijn van

slachtoffers van algemeen koppelgeweld te generaliseren naar de Vlaamse bevolking. Sommige beperkingen van dit soort bevolkingsonderzoek zijn noemenswaardig. Vooreerst staat bevolkingsonderzoek erom gekend om omwille van "selectie bias" eerder een *onder*schatting te rapporteren van het voorkomen van IPG in de algemene bevolking (Krahé et al., 2005). Dus, de werkelijke prevalentie cijfers zijn wellicht hoger dan de gerapporteerde cijfers. Ten tweede zijn de resultaten van deze verschillende studies gebaseerd op zelf-rapportage van de respondenten. We weten dus niet zeker in welke mate deze bevindingen overeenkomstig zijn met gedragsmetingen. Ten derde kunnen deze resultaten enkel veralgemeend worden naar personen die te maken kregen met lichte vormen van algemeen koppelgeweld en niet naar slachtoffers van intiem terrorisme. Een laatste beperking heeft betrekking op het aantal vragenlijsten die kunnen opgenomen worden in bevolkingssteekproeven. Zoals in ander bevolkingsonderzoek was er in het huidig doctoraatsonderzoek slechts ruimte voor verkorte versies van een beperkt aantal gevalideerde vragenlijsten. Dit beperkt een grondige evaluatie van het verband tussen IPG en relationele correlaten.

Een belangrijke meerwaarde van dit doctoraatsonderzoek is dat we psychologisch IPG mee opgenomen hebben in onze studies. Echter, enkele bedenkingen kunnen gemaakt worden bij de manier waarop psychologisch IPG gemeten werd. Zoals het merendeel van de onderzoeken hebben wij psychologisch geweld louter bevraagd aan de hand van een reeks concrete gedragingen. We peilden niet naar de mate waarin personen deze gedragingen zelf als psychologisch geweld percipieerden. Verder werd dit geweld in alle studies op gelijkaardige manier bevraagd. Personen met een andere culturele achtergrond en niet-heteroseksuele personen kunnen echter ook enkele additionele of andere vormen van psychologisch geweld ervaren.

Beleidsimplicaties

Met onze resultaten hopen we bij te dragen aan de empirische grondslag die nodig is om deze problematiek grondig aan te pakken op beleidsniveau. Ten eerste hebben onze studies bijgedragen aan up-to-date IPG prevalentie cijfers voor België en Vlaanderen. De laatste cijfers dateerden van 1998 (Bruynooghe, Nolanders, & Opdebeeck, 1998). Een belangrijke opmerking dient hierbij echter geformuleerd te worden. Zoals reeds vernoemd is bevolkingsonderzoek een geschikte tool om informatie te verzamelen over algemeen koppelgeweld. Indien beleidsmakers echter beslissingen willen maken inzake de nood aan en het aantal financiële middelen die moeten vrijgemaakt worden voor slachtoffers en daders van intiem terrorisme is bijkomend onderzoek nodig bij specifieke doelgroepen. Ten tweede, het nationaal actieplan tegen partnergeweld 2010 – 2014 (NAP) bespreekt het belang van aandacht voor IPG bij etnische minderheidsgroepen in België. Met onze cijfers hopen we het belang hiervan verder te onderstrepen opdat deze slachtoffers ook voldoende geïnformeerd worden over de problematiek alsook op ondersteuning kunnen rekenen. Ten derde hopen we dat met onze studie naar IPG bij niet-heteroseksuele personen op maatschappelijk niveau meer expliciet zal gemeld worden dat geweld in alle intieme relaties kan voorkomen, ongeacht seksuele voorkeur. Ten slotte formuleren we nog een algemene beleidsaanbeveling. Standaardisatie van onderzoek, zowel in tijd als in meetinstrumenten, zou ons een meer coherent en compleet begrip van het fenomeen opleveren.

Klinische Implicaties

Relatieproblemen zijn een belangrijke reden waarom mensen de stap zetten naar psychotherapie (Bradbury & Karney, 2010; Bradbury, Fincham, & Beach, 2000). Echter, personen of koppels in therapie melden dikwijls niet spontaan dat er sprake is / was van

IPG in hun huidige of vorige partnerrelatie. Het is de taak van de therapeut om dit taboe bespreekbaar te maken en te peilen naar mogelijkse geweldervaringen. Dit kan door aandacht te hebben voor de conflictstrategieën van koppels, zowel in hun huidige als vorige partnerrelatie. Mogelijks interageren partners in hun huidige partnerrelatie op basis van eerdere relatie ervaringen in een intieme partnerrelatie (Metz & Epstein, 2002).

Gezien het verminderd relationeel welzijn van slachtoffers vermoeden we dat relatietherapie koppels kan helpen die te kampen hebben met relatiemoeilijkheden omwille van een voorgeschiedenis met algemeen koppelgeweld. Verschillende theoretische modellen kunnen gehanteerd worden als vertrekbasis. Zo is er bijvoorbeeld, de "emotionally focused couple therapy" (EFCT; Johnson, 1996, 2003) die gebaseerd is op de hechtingstheorie (Bowlby 1969/1982, 1973). Gegeven het feit dat de slachtoffers in onze studies meer onveilige hechting rapporteerden geloven we dat dit een zinvolle therapie is om slachtoffers' huidige relatiemoeilijkheden aan te pakken. Dit therapeutisch model stelt dat het exploreren van de "schade" die aangericht werd door aversieve eerdere relationele ervaringen, slachtoffers helpt in het begrijpen hoe ze zich hechten aan hun huidige partner. De focus van deze therapie is het evalueren en aanpassen van hechting gerelateerde gedachten en gevoelens op basis van nieuwe positieve relatie ervaringen. Een andere therapievorm, de cognitieve gedragstherapie, is gebaseerd op de sociale leertheorie. Deze therapie is zinvol om koppels' algemene interactiepatronen in kaart te brengen. Er wordt gewerkt rond het bewerkstelligen van positieve relatie uitkomsten door het voorschrijven van nieuwe gedragsregels voor beide partners (Bradbury & Karney, 2010).

Toekomstig Onderzoek

Een eerste suggestie voor verder onderzoek betreft de manier waarop IPG gemeten wordt. Naast het bevragen van wat personen meegemaakt hebben lijkt het

ons van cruciaal belang om de context van dit geweld mee in rekening te brengen (zie Johnson, 2008). Op die manier kan er een duidelijker onderscheid gemaakt worden tussen intiem terrorisme (i.e., controle tactieken) en algemeen koppelgeweld (i.e., geëscaleerd conflict). Verder geloven we in het belang van verder onderzoek, zowel conceptueel als empirisch, naar psychologisch IPG (Follingstad, 2007; McHugh, Rakowski, & Swiderski, 2013). Een tweede suggestie heeft betrekking op het longitudinaal onderzoeken van het welzijn van IPG slachtoffers. De cross-sectionele aard van onze studies laat geen causale uitspraken toe. Daarom moeten we voorzichtig omspringen met de veronderstellingen dat onze relationele correlaten uitkomsten zijn van het ervaren van IPG. Een derde suggestie betreft dyadisch onderzoek. In de context van algemeen koppelgeweld zou het interessant zijn om de relatiedynamieken in kaart te brengen met behulp van beide partners (Bartholomew & Cobb, 2011; Winstok, 2007). Een laatste aanbeveling refereert naar het belang van mediatieanalyses. Gegeven de uitgesproken verbanden tussen IPG en welzijn lijkt het ons aangewezen om onderliggende factoren die dit verband beïnvloeden te identificeren (Weston, 2008).

ALGEMENE CONCLUSIE

Onenigheid en conflict zijn inherent aan intieme partnerrelaties. Jammer genoeg zoeken heel wat koppels hun toevlucht in geweld wanneer ze geconfronteerd worden met situaties die niet stroken met hun persoonlijke belangen en interesses (Bradbury & Karney, 2010). In dit doctoraatsonderzoek hebben we verschillende representatieve bevolkingsonderzoeken gebruikt om het voorkomen van fysiek en psychologisch partnergeweld in verschillende groepen van mensen na te gaan, zoals bijvoorbeeld bij personen van Turkse origine in Vlaanderen en bij niet-heteroseksuele personen. Zoals verwacht is IPG een globaal fenomeen dat geen culturele grenzen of grenzen naar seksuele voorkeur kent. Algemeen kunnen we stellen dat zowel heteroseksuele mannen

en vrouwen als mannen en vrouwen van Turkse afkomst in Vlaanderen en niet-heteroseksuele mannen en vrouwen ooit in hun leven te maken krijgen met partnergeweld. Het betreft veelal licht tot mild partnergeweld. Verder vonden we dat ervaring met IPG gepaard gaat met een verminderd mentaal welzijn, en mensen vatbaar maakt voor een minder goed relationeel welzijn in (latere) intieme partnerrelaties gekenmerkt door minder relatietevredenheid, seksuele tevredenheid, seksuele communicatie, en meer onveilige hechting en seksuele disfuncties. Gegeven het feit dat in een intieme partnerrelatie zelfs lichte vormen van algemeen koppelgeweld gerelateerd zijn een verminderd relationeel en seksueel welzijn hopen we dat de verschillende studies in dit doctoraatsonderzoek bijdragen tot meer onderzoek in de toekomst naar de relationele correlaten van IPG in klinische en niet-klinische steekproeven.

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